

1

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be left to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

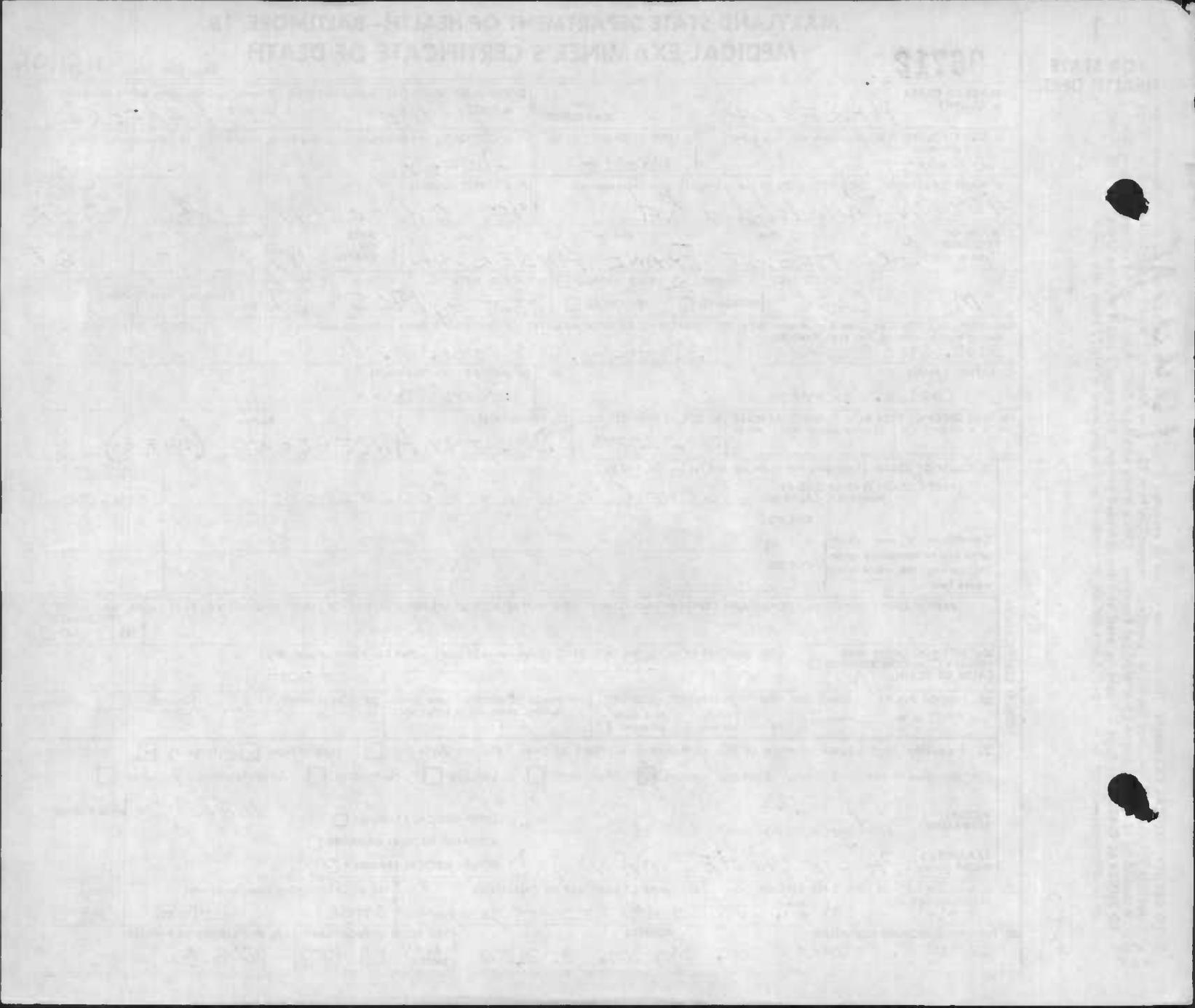
FOR STATE  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

06698

06712									
1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY HARFORD							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JOPPA		c. LENGTH OF STAY IN 1b Lifetime							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 409 Old Philadelphia Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CARL AUGUST FRANK ANDERSON		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX M		6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT 5, 1905	9. AGE (In years last birthday)	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Pipe Shop		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt-Ret.		11. BIRTHPLACE (State or foreign country) Joppa, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Carl A. Anderson		14. MOTHER'S MAIDEN NAME Barbara Fisher							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-20-7276		17. INFORMANT DOROTHY ANDERSON (WIFE)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>HACO</i>		Acute Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH INSTANT	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO							
{		DUE TO							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Philip W. Heuman</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						MAY 17, 1967 DATE SIGNED	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 20, 1967		22c. NAME OF CEMETERY OR CREMATORIUM Trinity Lutheran Cemetery		22d. LOCATION (City, town, or county) Joppa		(State) Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md. 21009		ADDRESS						24a. REC'D BY REGISTRAR MAY 19 1967	24b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06713

CERTIFICATE OF DEATH

06699

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
3. NAME OF DECEASED (Type or print) GRACE MADELINE		First	Middle
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/>	7. DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAY 1, 1921		9. AGE (In years lost birthday) 46 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		11. BIRTHPLACE (County & State, or foreign country) Md. (Harford Co.)	
13. FATHER'S NAME W. SANNER BAILEY		14. MOTHER'S MAIDEN NAME HATTIE VIOLA PRESTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-12-9257	
17. INFORMANT (Brother) Mr. Tom BAILEY		Address 12 FOREST DRIVE BEL AIR, MARYLAND 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemic Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gram - Negative Bacteria + Enteritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Laennec's Cerebral ② Dehydration + hypokalemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 12, 1967, to May 13, 1967 that (I) (we) last saw the deceased alive on May 13, 1967, and that death occurred at 30 M, fram causes and an the date stated above.			
22o. SIGNATURES Edward C. LEONARD		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/13/67
22c. PHYSICIAN'S NAME (Type) Edward C. LEONARD		22d. ADDRESS Havre de Grace, Md.	
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS W. Broadway & Williams St.		23d. LOCATION (City, Town) (County) (State) BEL AIR, HARFORD CO, MARYLAND 21014	
24. FUNERAL DIRECTOR Joseph William Foster		25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BEL AIR, MARYLAND 21014			16 1967 GLENDALE JUDGE

2400

1973-10-30

6173

241

(continued) - New species  
and genera added

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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06714

**CERTIFICATE OF DEATH**

06700

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>			c. LENGTH OF STAY IN lb <b>4 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Ella Josphine Brown</b>			First	Middle	Last
4. DATE OF DEATH <b>MAY 27 1967</b>	Month	Day	Year		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 28 1902</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>124 WILSON ST.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MASS.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>WILLIS JACOBS</b>			14. MOTHER'S MAIDEN NAME <b>GEORGINA BOYD</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO. <b>216-46-8262</b>	17. INFORMANT <b>Mr. FOREST E. BROWN HAURE DE GRACE MD</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Cardiovascular disease.</b>
			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>524</b>	20f. (City or town) <b>Harford</b> (County) <b>Co. Md.</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 27</b> , 1967, to <b>May 27</b> , 1967, that (I) (we) last saw the deceased alive on <b>May 27</b> , 1967, and that death occurred at <b>524</b> , <b>Harford</b> , <b>Co. Md.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Edward C. Lewis</b>			M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <b>Edward C. Lewis</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>5/29/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Lewis</b>			22d. ADDRESS <b>Haure de Grace, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>			23b. DATE THEREOF <b>MAY 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>HARFORD MEMORIAL GARDENS</b>	23d. LOCATION (City or Town) (County) (State) <b>Harford Co. Md.</b>
24. FUNERAL DIRECTOR <b>R. Madison Mitchell</b>			ADDRESS <b>HAURE DE GRACE NO. 524</b>	25a. REC'D BY REGISTRAR DATE <b>JUN 1 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

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06715		06701							
1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b>		c. LENGTH OF STAY IN 1b <b>16 hrs 45 min</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kirk Army Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood Arsenal</b>							
d. STREET ADDRESS <b>6201 C Baker Circle</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Lisa</b>		First <b>Lisa</b>	Middle <b>(none)</b>	Last <b>CLARK</b>	4. DATE OF DEATH <b>May 16, 1967</b>	Month <b>May</b>	Doy <b>17</b>	Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1967</b>	9. AGE (In years lost birthday) yrs. <b>16</b>	IF UNDER 1 YEAR Months <b>16</b>	IF UNDER 24 HRS Days <b>45</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Roosevelt Clark</b>				14. MOTHER'S MAIDEN NAME <b>Minnie R. Bottoms</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Mother (Same as above)</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO last (c) _____									INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs 45min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>16 May</b> , 19 <b>67</b> , to <b>May 17</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>May 17</b> 19 <b>67</b> , and that death occurred at <b>12:55 AM</b> , from causes and on the date stated above.									22a. SIGNATURE <i>Thomas J. Green</i>
22c. PHYSICIAN'S NAME (Type) <b>THOMAS J. GREEN, CPT, MC</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>17 May 1967</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 19, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>A.P.G. Post Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Aberdeen Proving Ground, Md.</b>			
24. FUNERAL DIRECTOR <i>Lee A. Patterson &amp; Son, Perryville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAY 29 1967</b>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

1970-1971  
1971-1972  
1972-1973  
1973-1974

Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1970-71	100% Baptist	100% Baptist	100% Baptist	100% Baptist
1971-72	100% Baptist	100% Baptist	100% Baptist	100% Baptist
1972-73	100% Baptist	100% Baptist	100% Baptist	100% Baptist
1973-74	100% Baptist	100% Baptist	100% Baptist	100% Baptist

1970-1971  
1971-1972  
1972-1973  
1973-1974

Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1970-71	100% Baptist	100% Baptist	100% Baptist	100% Baptist
1971-72	100% Baptist	100% Baptist	100% Baptist	100% Baptist
1972-73	100% Baptist	100% Baptist	100% Baptist	100% Baptist
1973-74	100% Baptist	100% Baptist	100% Baptist	100% Baptist

1970-1971  
1971-1972  
1972-1973  
1973-1974

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**M**  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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<b>CERTIFICATE OF DEATH</b>																	
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY <b>HARFORD</b> MARYLAND						a. STATE <b>Md</b> b. COUNTY <b>HARFORD</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>			c. LENGTH OF STAY IN 1b <b>1 week</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			d. STREET ADDRESS <b>44 Fenway St.</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED First <b>Marie</b> Middle <b>F.</b> Last <b>Copeland</b>			4. DATE OF DEATH <b>May 16</b>			Month <b>1967</b>			Day <b>1967</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-12-22</b>		9. AGE (In years last birthday) <b>45 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Air-force Exchange</b>						11. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Walter Brown</b>						14. MOTHER'S MAIDEN NAME <b>Josephine Henderson</b>						Address <b>44 Fenway St.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b>						16. SOCIAL SECURITY NO. <b>231-22-3346</b>						17. INFORMANT <b>Mr. John E. Copeland, Aberdeen, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marie Myocardial Infarction</b> DUE TO <b>4201</b>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Hypertensive Cardiovascular disease</b> DUE TO <b>last.</b>																	
DUE TO <b>(c) Coronary Thrombosis</b>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>10A</b> (County) <b>Holland</b> (State) <b>Virginia</b>								
21. I certify that (I) (this hospital) attended the deceased from <b>May 12, 1966</b> to <b>May 16, 1967</b> that (I) (we) last saw the deceased alive on <b>May 16, 1967</b> , and that death occurred at <b>10A</b> M, from causes and on the date stated above.																	
22a. SIGNATURE <b>George T. Stansbury</b>						M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>5/16/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>						22d. ADDRESS <b>569 Revolution St. Havre de Grace, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>May 21, 1967</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Laurel Hill Christian Cem.</b>			23d. LOCATION (City or Town) <b>Holland</b> (County) <b>Virginia</b> (State) <b>Virginia</b>								
24. FUNERAL DIRECTOR <b>Flower E. Billings</b>						25a. ADDRESS <b>55-6 Lewis St</b>			25a. REC'D BY REGISTRAR <b>MAY 22 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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06717

CERTIFICATE OF DEATH

06703

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be retained by the hospital or attending physician. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 16 1 yr. 2 mo.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Convalescing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First IRIS	Middle V.	4. DATE OF DEATH Lost CULLUM Month MAY Day 17 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1880			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years last birthday) 86 yrs.			
13. FATHER'S NAME James Kyle		14. MOTHER'S MAIDEN NAME Annie Bird				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-54-9070-T	17. INFORMANT Address Bel Air, Md. Mrs. Flossie V. Hooper, 404 Giles St.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, terminating</u>		INTERVAL BETWEEN ONSET AND DEATH 5 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) <u>Chronic Hypertensive ASCVD</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>4/14/</u> , 19 <u>56</u> , to <u>5/17</u> , 19 <u>67</u> , that (I) <u>saw the deceased alive on 5/16/</u> 19 <u>67</u> , and that death occurred at <u>10 a.m.</u> , from causes and on the date stated above.						
22a. SIGNATURE <u>Willard P. Hudson</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.		22b. DATE SIGNED 5/18/1967				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens	23d. LOCATION (City or Town) Bel Air	(County) Harford	(State) Md
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		ADDRESS		25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
				DATE MAY 19 1967 <u>Charles Judge</u>		

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06718

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Hanford</b>		Md MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>3807 Fleetwood</b>		b. COUNTY <b>Balti.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brevin Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>421 S Union St</b>			
3. NAME OF DECEASED (Type or print)	First <b>Charlotte ANNIE</b>	Middle	Last <b>Cundiff</b>	4. DATE OF DEATH	Month <b>5-</b>	Doy <b>18</b>	Year <b>1967</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-1893</b>	9. AGE (In years lost birthday) <b>74 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Knoxville Tenn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm C Sheen</b>		14. MOTHER'S MAIDEN NAME <b>JANET BOWMAN</b>		Address <b>N daug.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-6428</b>		17. INFORMANT <b>Brevin</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central - vascular hemorhage</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerosis generalized</b>		DUE TO (b) <b>Glaucoma</b>		DUE TO (c) <b>Ullner</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/1/67</b> , to <b>5/18/67</b> , that (I) (we) last saw the deceased alive on <b>5/18/67</b> , and that death occurred at <b>18</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Janet Bowman</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>421 S Union St</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-22-1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>2401 Belair Road</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
VR A15 (4) 20 M 1/66							

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>													
1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de Grace</b>				c. LENGTH OF STAY IN lb <b>1b</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hospital</b>				e. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de Grace</b>									
d. STREET ADDRESS <b>240 Bloomsbury Ave</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First <b>DAVID</b>	Middle <b>R</b>	Last <b>Curry</b>	4. DATE OF DEATH Month <b>MAY</b>	Day <b>6</b>	Year <b>1967</b>						
5. SEX <b>Male</b>		6. COLOR DR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVDRCD	B. DATE OF BIRTH <b>Mar. 11, 1911</b>	9. AGE (In years less birthday) <b>56</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	10. KIND OF BUSINESS OR INDUSTRY <b>DISABILITY</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>A.S.A.</b>			
13. FATHER'S NAME <b>GEORGE A. CURRY</b>		14. MOTHER'S MAIDEN NAME <b>SARAH JANE MORRIS</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-18-3970</b>				17. INFORMANT <b>Mr. Tatia M. Curry, HAURE de Grace, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>				Address <b>INTERVAL BETWEEN ONSET AND DEATH HOURS</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>ASCVD</b>				DUE TO <b>MYOCARDIAL INFARCTION</b>									
				DUE TO <b>ASCVD</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY ENPHYSEMA</b>				DUE TO <b>ASCVD</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>May 6 1967</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>BEL AIR</b>		(County) <b>MD.</b>		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 6 1967</b> to <b>May 6 1967</b> , that (I) (we) last saw the deceased alive on <b>May 6 1967</b> , and that death occurred at <b>335 M</b> , from causes and on the date stated above.													
22a. SIGNATURE <b>Maydeleka</b>				22b. DATE SIGNED <b>5-6-67</b>									
22c. PHYSICIAN'S NAME (Type) <b>S. LEYTE-V.D.A.L</b>				22d. ADDRESS <b>114 W. BEL AIR AVE. ABERDEEN, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>May 10, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>ASBURY CEM.</b>		23d. LOCATION (City or Town) <b>Cecil</b>		(County) <b>MD.</b>		(State)	
24. FUNERAL DIRECTOR <b>K. Hodson Mitchell, Haure de Grace, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 10 1967</b>									
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

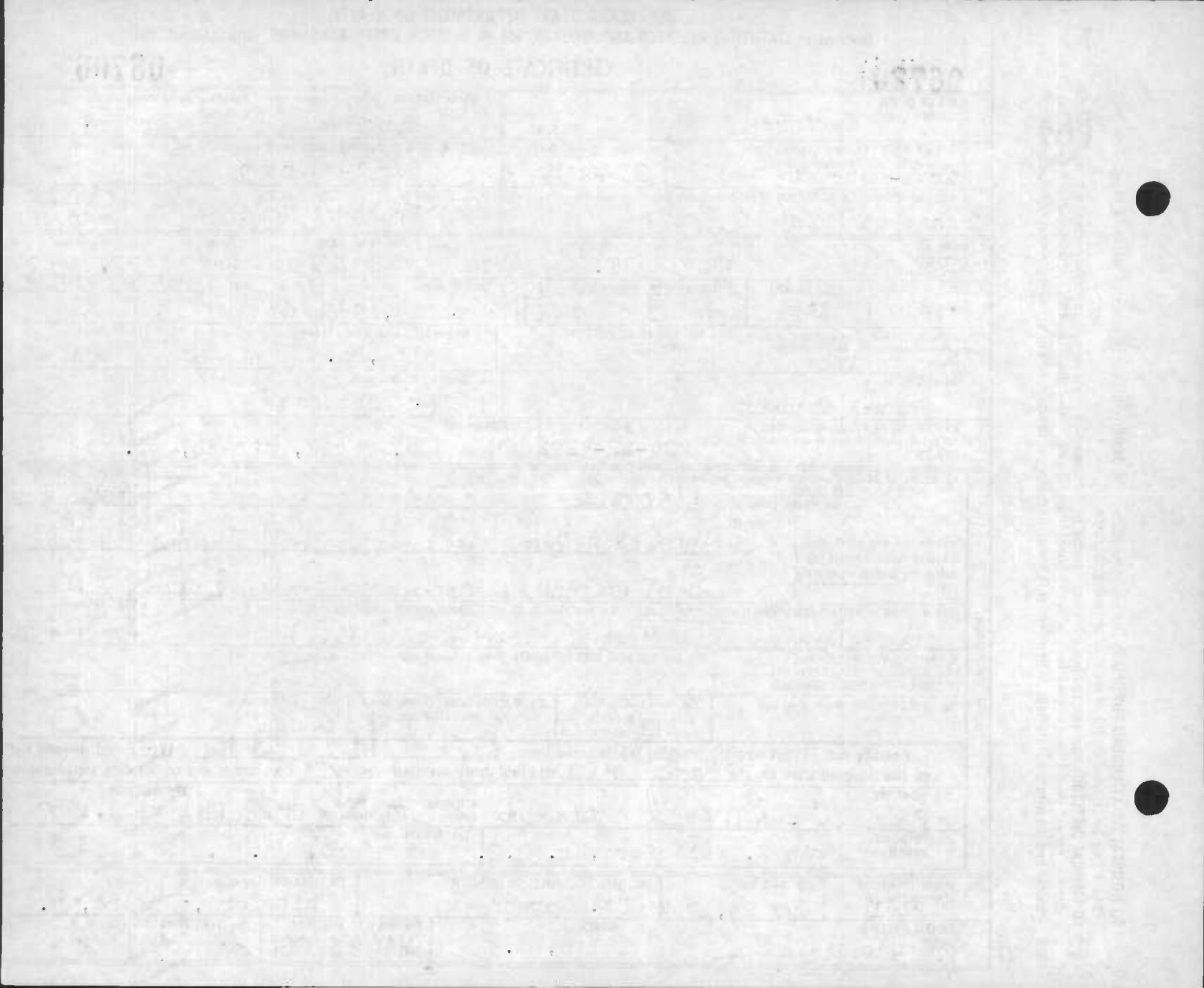
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician.

should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Street</b>		c. LENGTH OF STAY IN lb <b>33 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prospect Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IRENE</b>		First <b>T.</b>	Middle <b>DAVIS</b>
Last <b>May</b>		4. DATE OF DEATH Month <b>22, 1967</b>	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>March 15, 1903</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Delta, Pa.</b>	
13. FATHER'S NAME <b>Samuel Tarbert</b>		14. MOTHER'S MAIDEN NAME <b>Mary Grimes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-12-4272</b>	
17. INFORMANT <b>Thomas S. Davis, Street, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
DUE TO (b) Advanced arteriosclerosis + cerebral Thrombosis 6 mo.			
DUE TO (c) Right perinephric abscess + non-functioning kidney 8 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension - Morbid pneumonia (3days)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Whiteford, Harford, Md.</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1957</b> , to <b>22 May 1967</b> , that (I) (we) last saw the deceased alive on <b>22 May 1967</b> , and that death occurred at <b>4:35 P.M.</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>May 23, 1967</b>	
22c. SIGNATURE <b>Edwin W. Whiteford, Jr. M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Whiteford, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 25, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Vernon</b>
23d. LOCATION (City or Town) <b>Whiteford, Harford, Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>John H. Harkins</b>		ADDRESS <b>Delta, Pa.</b>	25a. REC'D BY REGISTRAR <b>MAY 25 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06721

CERTIFICATE OF DEATH

06708

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Street		c. LENGTH OF STAY IN 1b 46 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Doyle Road		d. STREET ADDRESS Doyle Road					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) J. KENNETH		First Middle J. KENNETH	4. DATE OF DEATH Month May 29, 1967 Doy Year				
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1888	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (County & State, or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Doyle		14. MOTHER'S MAIDEN NAME Mary M. Frederick		Address Thomas F. Doyle, Street, Md.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-36-0200		17. INFORMANT Thomas F. Doyle, Street, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> INTERVAL BETWEEN ONSET AND DEATH 420/1 1.9 min. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Advanced atherosclerotic cardiovascular disease</i> 6 yr. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Exogenous obesity - osteoarthritis - knees - spastic colon</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1960, to <i>29 May</i> , 1967, that (I) (we) last saw the deceased alive on <i>22 May</i> 1967, and that death occurred at <i>6:45 PM</i> , from cause and on the date stated above.		22a. SIGNATURE <i>Edwin W. Whiteford, Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 31, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin W. Whiteford, Jr. MD		22d. ADDRESS Whiteford, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Emory		23d. LOCATION (City or Town) (County) (State) Street, Harford Co., Md.	
24. FUNERAL DIRECTOR John H. Hardin		ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR DATE JUN 8 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

78730

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06709

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M		06722		CERTIFICATE OF DEATH		06709		
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
o. COUNTY <i>HARFORD</i>		o. STATE <i>MARYLAND</i>		b. COUNTY <i>HARFORD</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAUKE DE GRACE</i>		c. LENGTH OF STAY IN LB <i>10 DAYS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAUKE DE GRACE</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>HARFORD MEMORIAL HOSP. 126 So. Wash. ST</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>ANNA LAURA ERVIN</i>		First	Middle	Lost	4. DATE OF DEATH <i>MAY 6 1967</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>APRIL 29, 1897</i>	9. AGE (In years last birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (County & State, or foreign country) <i>M.D.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>JOSEPH FRANCIS CRAWFORD</i>		14. MOTHER'S MAIDEN NAME <i>LAURA V. McEVIN</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>217-07-7446</i>		
17. INFORMANT <i>Mrs. Virginia E. Hilcomb</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO <i>Anterior clavicular (heart disease)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) OUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20. MEDICAL CERTIFICATION		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>May 6 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>HARFORD</i>	(County) <i>M.D.</i>	(State)
20c. 21. I certify that (I) (this hospital) attended the deceased from <i>April 27, 1967</i> , to <i>May 6, 1967</i> that (I) (we) last saw the deceased alive on <i>May 6, 1967</i> , and that death occurred at <i>7 AM</i> , from causes and on the date stated above.		22. SIGNATURE <i>Frank W. Johnson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5/6/67</i>	
22c. PHYSICIAN'S NAME (Type)		23b. DATE THEREOF <i>May 9, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>HARFORD MEMORIAL GARDENS</i>	23d. LOCATION (City or Town) <i>HARFORD</i>	(County) <i>M.D.</i>	(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24. FUNERAL DIRECTOR <i>R. Madison Mitchell, HARFORD, M.D.</i>		ADDRESS	25a. RECEIVED BY REGISTRAR DATE <i>MAY 10 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06723

CERTIFICATE OF DEATH

06710

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
<i>Hartford</i> <i>Hartford</i>		7 Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Hartford-de-Grace</i>		3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Hartford Memorial Hospital</i>		<i>Joppa</i> <i>Magnolia Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <i>Lorean</i> Middle <i>May</i> Surname <i>Faine</i>		Month <i>5</i>	Day <i>4</i> Year <i>1967</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Presser</i>		9. AGE (In years lost birthday) <i>57 yrs.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Sewing Factory</i>		11. BIRTHPLACE (County & State, or foreign country) <i>W. Va.</i>	
13. FATHER'S NAME <i>Jack Martin</i>		14. MOTHER'S MAIDEN NAME <i>Arama Arrow</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>233-28-8342</i>	
17. INFORMANT		Address <i>Mr. Troy Faine, Magnolia Rd., Joppa, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left cerebral vascular accident</i> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i></span> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Calciosomatosis - left breast cancer.</i>		(b) <i>Calciosomatosis - left breast cancer.</i> <span style="float: right;"><i>2 yrs.</i></span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>May</i> 19 p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Felt</i> (County) <i>May</i> (State) <i>1967</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb.</i> , 1967, to <i>May</i> , 1967, that (I) (we) last saw the deceased alive on <i>May 4</i> , 1967, and that death occurred at <i>9:50 PM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>5/4/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.H. Sadowsky</i>		22d. ADDRESS <i>504 Lewis St. Hanover, Md.</i>	
23c. NAME OF CEMETERY OR CREMATORIALY <i>Harford Memorial Gardens</i>		23d. LOCATION (City or Town) <i>Aberdeen</i> (County) <i>R.D. Harford</i> (State) <i>Md.</i>	
23e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23f. DATE THEREOF <i>May 8, 1967</i>	
24. FUNERAL DIRECTOR <i>Howard K. McComas &amp; Son, Abingdon, Md. 21009</i>		ADDRESS	
		25a. REC'D BY REGISTRAR DATE <i>MAY 8 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

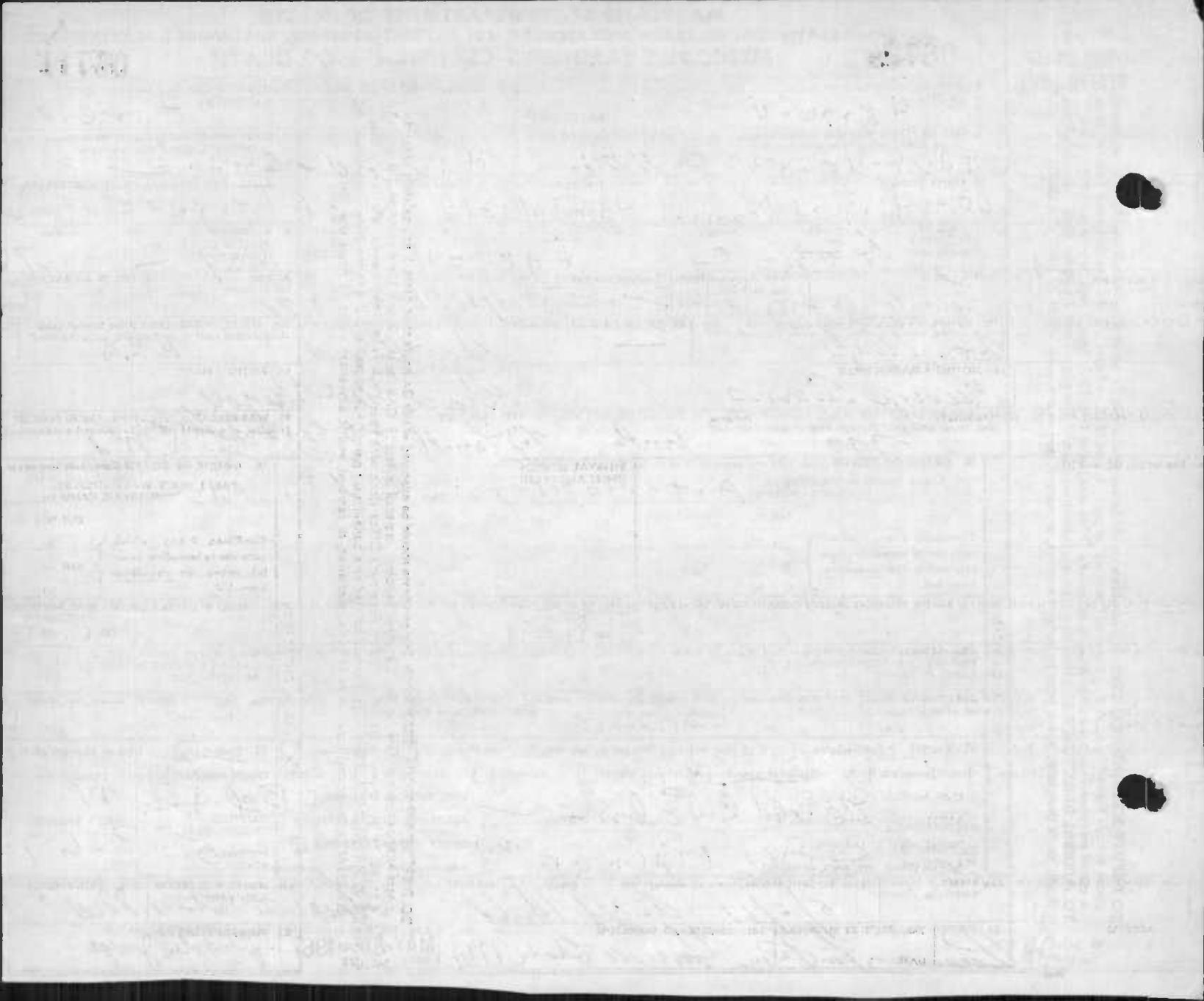
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06724

06711

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residencia before admission)	
Harrowd		a. STATE	b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
Harrowd		4 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS	
DCA Harford Memorial Hospital		614 Chapel Terrace	
3. NAME OF DECEASED (Type or print)		First	Middle
Grace		Farrer	I
4. DATE OF DEATH		Month	Day
May 2			1967
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED		8. DATE OF BIRTH	
<input type="checkbox"/> NEVER MARRIED		10/21/1895	
<input checked="" type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House Wife		—	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Scotland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Cairns		Grace McGregor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO			
Conditions, if any, which gave rise to immediate cause (b)			
{ (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE		DATE SIGNED	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL
5/6/67		Angel Hill	
23. FUNERAL DIRECTOR		ADDRESS	24a. REC'D BY REGISTRAR MAY 8 1967
Dwight L. Palmer, Harford, Md.			24b. REGISTRAR'S SIGNATURE Charles Judge



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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>MARYLAND STATE DEPARTMENT OF HEALTH</b>											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<b>CERTIFICATE OF DEATH</b>											
06725			05712								
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)								
Harford			e. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville			b. COUNTY Harford								
c. LENGTH OF STAY IN lb 2 Yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville RD #1 Box 627								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rockdale Ave.			d. STREET ADDRESS Rockdale Ave.								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First	Middle	Last	Month	Dey	Year	4. DATE OF DEATH	May	2, 1967
Grant Hazel Good									9. AGE (in years last birthday)	60 yrs.	IF UNDER 1 YEAR Months Dey Hours Min.
5. SEX			6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH				10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Male			White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/27/1906				Gen. farming	Pocahontas Co. W.Va.	U.S.A.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			14. MOTHER'S MAIDEN NAME								
Farmer			Maudie Ann Morrison								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-12-5814								
17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]								
Opal A. Good			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute pulmonary edema								
Churchville, Md. 21028			DUE TO (b) Atherosclerotic coronary artery disease								
			DUE TO (c)								
			15 yr.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Gastric carcinoma c obstruction at esophageal area								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Dey, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (his hospital) attended the deceased from Oct 1957 to 2 May 1967, that (I) (we) last saw the deceased alive on 2 May 1967, and that death occurred at 8:30 AM, from the causes and on the date stated above.			22b. DATE SIGNED 3 May 1967								
22c. PHYSICIAN'S NAME (Type) Edwin W. Whiteford Jr.			M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS Whiteford, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/5/1967			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Gardens			23d. LOCATION (City, town or county) (State) Bel Air Maryland		
24 FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz Jarrettsville, Md. 21084			ADDRESS			25a. REC'D BY REGISTRAR MAY 4 1967			25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT  
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**06726**

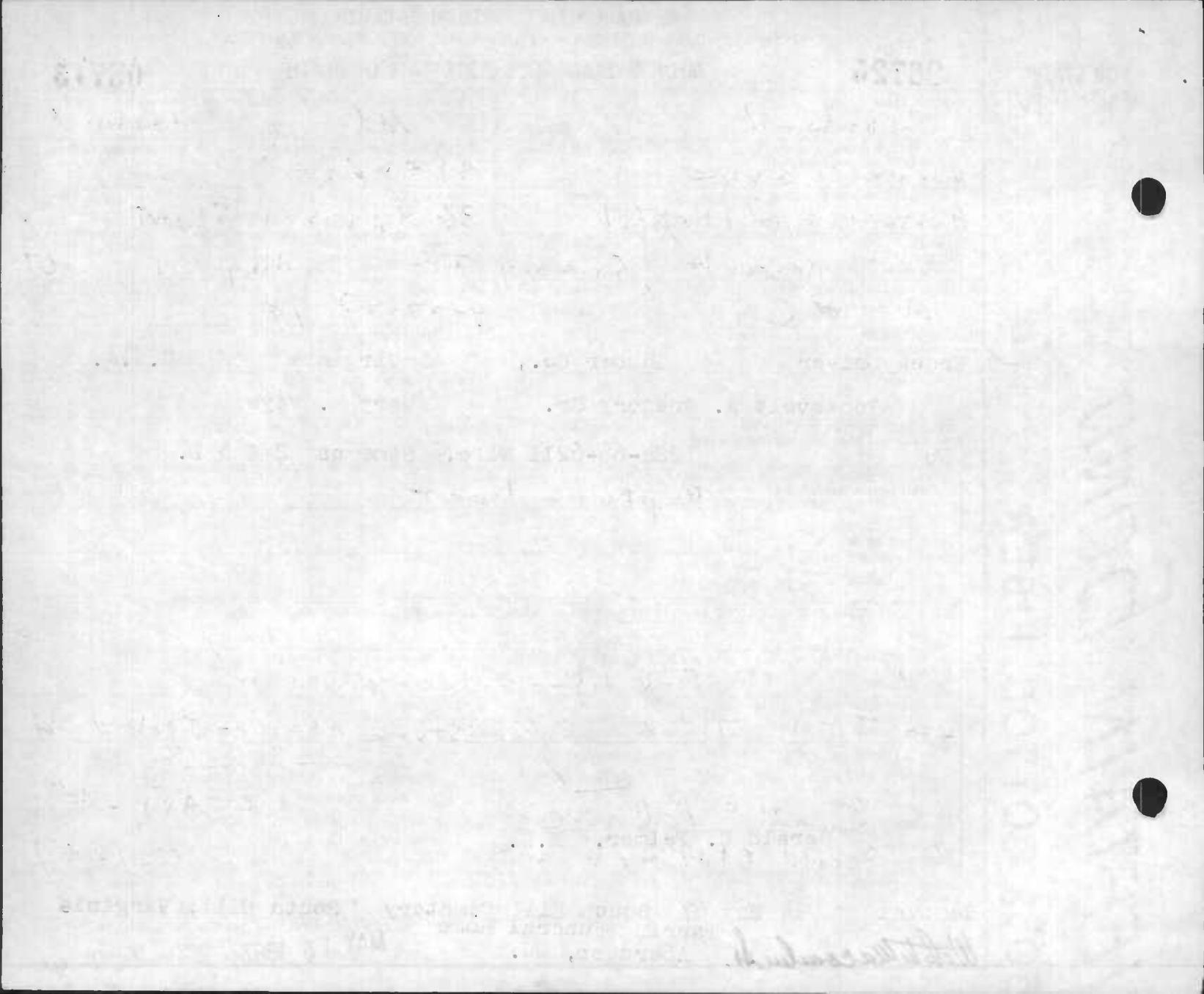
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**06713**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Hanover Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Hanover</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hanover Memorial Hospital</i>	d. STREET ADDRESS <i>36 Hanover Street</i>		
3. NAME OF DECEASED (Type or print) <i>Roosevelt A. Gregory</i>	First <i>Roosevelt</i>	Middle <i>A.</i>	Last <i>Gregory</i>
4. DATE OF DEATH <i>May 11 1967</i>	Month <i>May</i>	Doy <i>11</i>	Year <i>1967</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-27-47</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Lumber Co.,</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Roosevelt A. Gregory Sr.</i>	14. MOTHER'S MAIDEN NAME <i>Mary M. Mayo</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>224-66-6211</i>	17. INFORMANT <i>Wife, Same as 2 C &amp; D.</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture liver</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Fork lift overturned on him</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fork lift overturned on him</i>		
20c. TIME OF INJURY Month, Day, Year Hour <i>4:30 p.m.</i> Month <i>May</i> Day <i>11</i> Year <i>1967</i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Warehouse Aberdeen Maryland</i>	20f. (City or town) (County) (State) <i>Aberdeen</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C. Palmer</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Baltimore, Md.</i>		
EXAMINER'S NAME (Type) <i>Gerald C. Palmer, M.D.</i>	22. DATE SIGNED <i>5-12-67</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>14 May 67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>South Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>South Hill, Virginia</i>
24. FUNERAL DIRECTOR <i>Webster Macaulay Jr.</i>	Tarring ADDRS <i>Aberdeen, Md.</i>	25a. RECD. BY REGISTRAR <i>MAY 15 1967</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06727

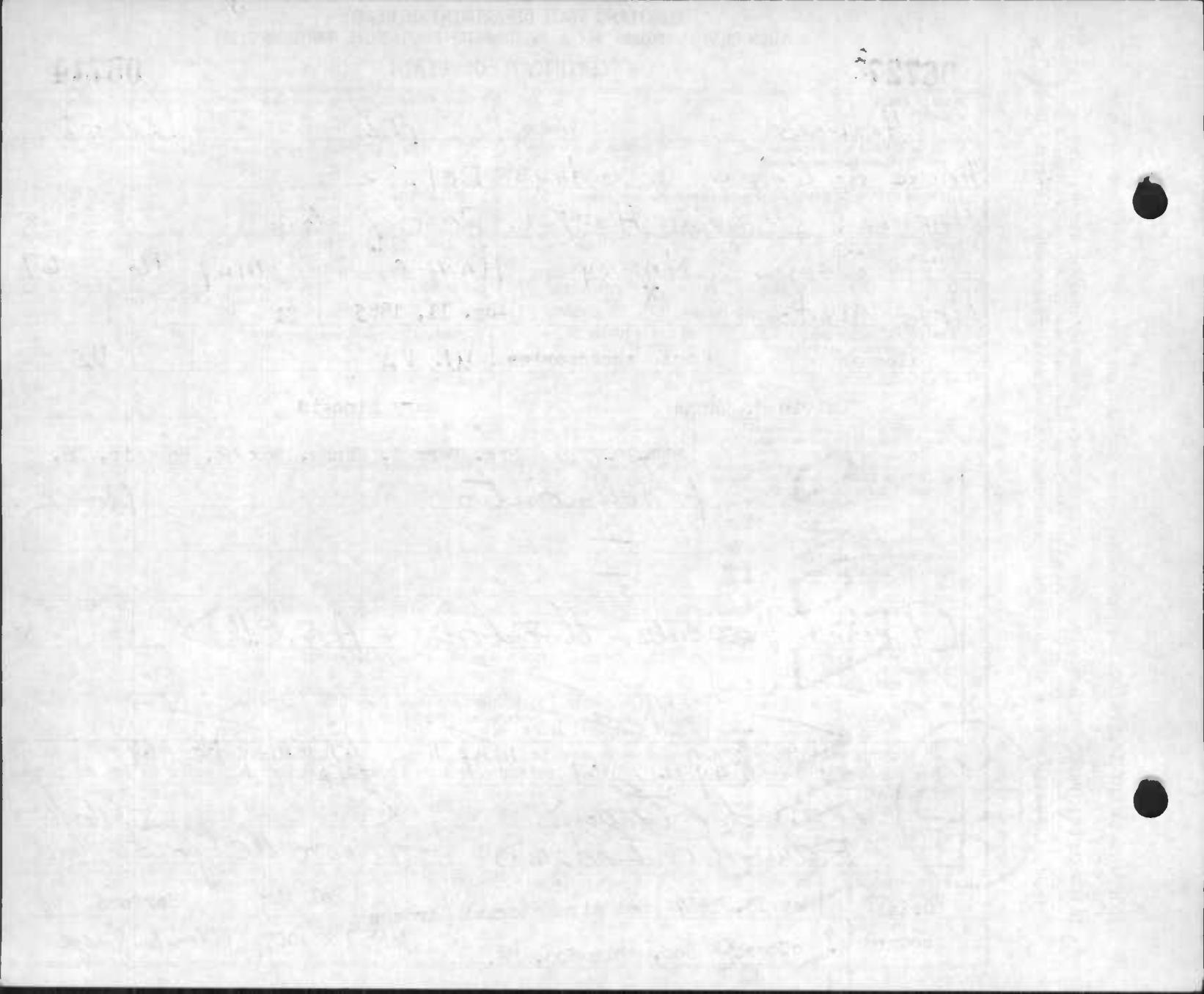
CERTIFICATE OF DEATH

06714

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

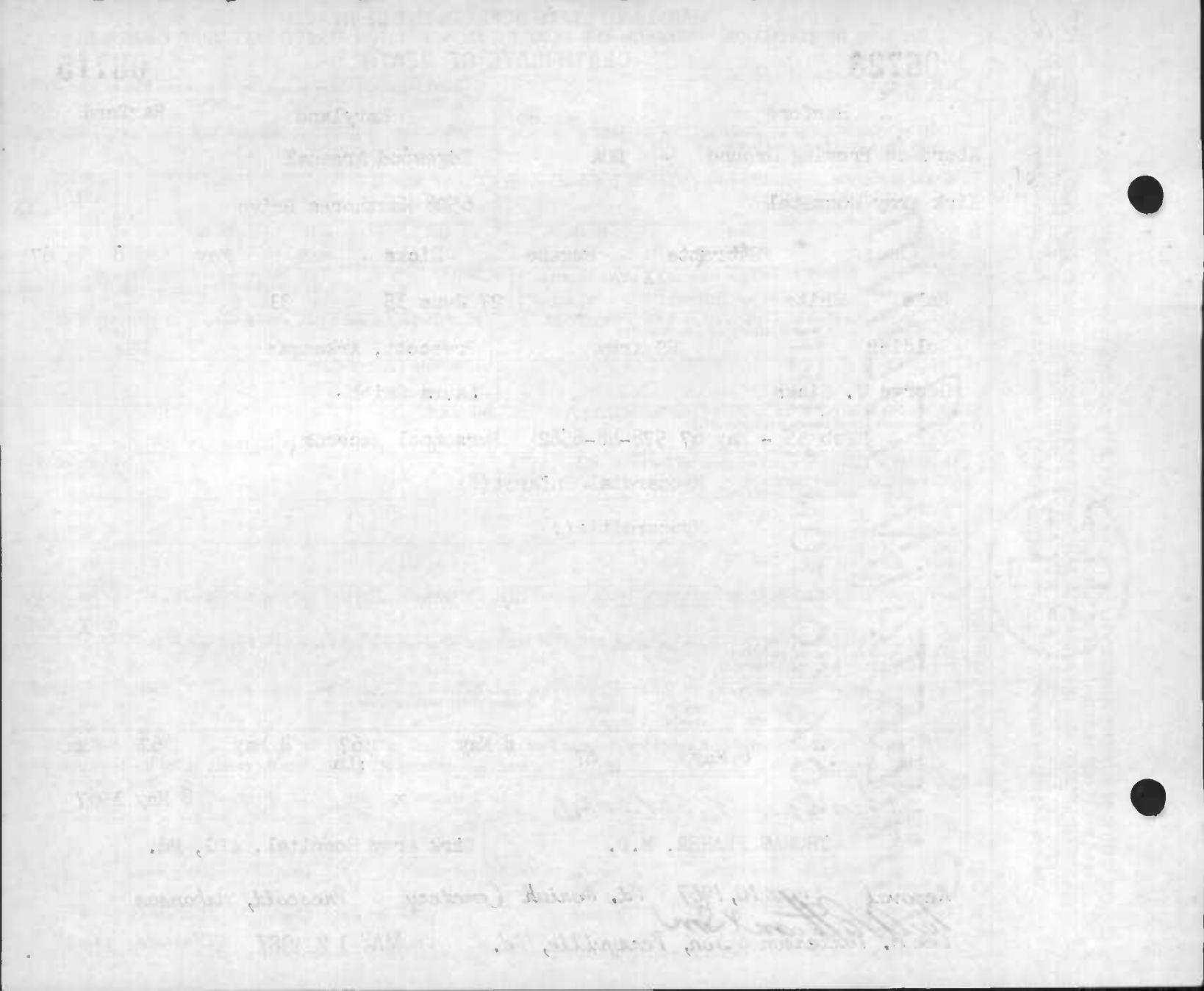
1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>		c. LENGTH OF STAY IN lb <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Belair</b>		d. STREET ADDRESS <b>Po. Box 62</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hospital</b>							
3. NAME OF DECEASED (Type or print) <b>JAMES HARRY HANNA</b>		First	Middle	Last	SR.	4. DATE OF DEATH <b>MAY 16 1967</b>	Month Doy Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <b>Aug. 11, 1885</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>auto accessories</b>		11. BIRTHPLACE (County & State, or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Calvin H. Hanna</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kincaid</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-20-7219</b>		17. INFORMANT <b>Mrs. Vera G. Hanna, Box 62, Bel Air, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>492x Pneumonitis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Vascular Thrombosis + A.S.C.V.D.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 11 1967</b> , to <b>MAY 16 1967</b> , that (I) (we) last saw the deceased alive on <b>MAY 16 1967</b> , and that death occurred at <b>2:55 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Edward C. Loo, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>		22d. ADDRESS <b>Haure de Grace, Md.</b>		22b. DATE SIGNED <b>5/16/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Bel Air Harford Md</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>				25a. RECED BY REGISTRAR DATE <b>MAY 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		06715			
1		06723		2		2		2		2		2		2	
1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE		Maryland		b. COUNTY		Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Aberdeen Proving Ground		c. LENGTH OF STAY IN 1b		DOA		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Edgewood Arsenal		d. STREET ADDRESS		e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Kirk Army Hospital		99		6508 Hawthorne Drive		d. STREET ADDRESS		6508 Hawthorne Drive		e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Everette		Middle Eugene		Last Hicks		4. DATE OF DEATH		Month May		Day 8		Year 1967	
5. SEX		6. COLOR OR RACE Male White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 June 35		9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Soldier		11. BIRTHPLACE (County & State, or foreign country) Prescott, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME George W. Hicks		14. MOTHER'S MAIDEN NAME Laura Smith													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. Feb 55 - May 67 578-48-8582		17. INFORMANT Personnel Records		Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN DNSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarct (?)													
4301 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Myocarditis (?)													
		DUE TO (c) Myocarditis (?)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Prescott, Arkansas		(County) Arkansas		(State) Arkansas					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 May 1967, to 8 May 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8 May 1967, and that death occurred at 5:00 AM, from the causes and on the date stated above.															
22a. SIGNATURE Thomas Fraher, MD												22b. DATE SIGNED 8 May 1967			
22c. PHYSICIAN'S NAME (Type)		THOMAS FRAHER, M.D.		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF May 10, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Moriah Cemetery		23d. LOCATION (City, town or county) Prescott, Arkansas						(State)			
24. FUNERAL DIRECTOR Lee A. Patterson & Son		ADDRESS Lee A. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR MAY 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge									



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06729

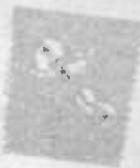
CERTIFICATE OF DEATH

06716

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with 24 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Hanover</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Md</i>		b. COUNTY <i>Hanover</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover, Md.</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hanover Memorial Hospital</i>				d. STREET ADDRESS <i>Rte 1</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
e. First <i>Charles</i>		Middle <i>Casper</i>		Last <i>Hiob Sr.</i>		Month <i>MAY</i>	Day <i>1</i>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH				Year <i>1967</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>23 April 1885</i>	
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electro Type &amp; Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		9. AGE (In years last birthday) <i>82 yrs.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Md. (Balto.)</i>	
13. FATHER'S NAME <i>Charles Casper Hiob (D)</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Kampe (D)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>213-05-8769</i>		17. INFORMANT <i>A) Wife, Same as 2 C &amp; D.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia and</i>		Address	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4500</i>		DUE TO (b) <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
		DUE TO (c) <i>Generalized Arthrosclerosis</i>		<i>1 yr</i>			
20c. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>May 1</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <i>Darlington</i> (County) <i>Md.</i> (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>May 1, 1960</i> , to <i>May 1, 1967</i> , that (I) (we) last saw the deceased alive on <i>May 1, 1967</i> , and that death occurred at <i>45 P.M.</i> from causes and on the date stated above.							
22c. SIGNATURE <i>Dudley Phillips</i>		22b. DATE SIGNED <i>5/1/67</i>					
22c. PHYSICIAN'S NAME (Type) <i>Dudley Phillips MD</i>		22d. ADDRESS <i>Darlington Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/4/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St Paul Lutheran Cemetery</i>		23d. LOCATION (City or Town) <i>Aberdeen</i> (County) <i>Md.</i> (State)	
24. FUNERAL DIRECTOR <i>Arrington General Home</i>				25a. REC'D BY REGISTRAR <i>DAI 4 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



75720

*D. W. M. 1981*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06730

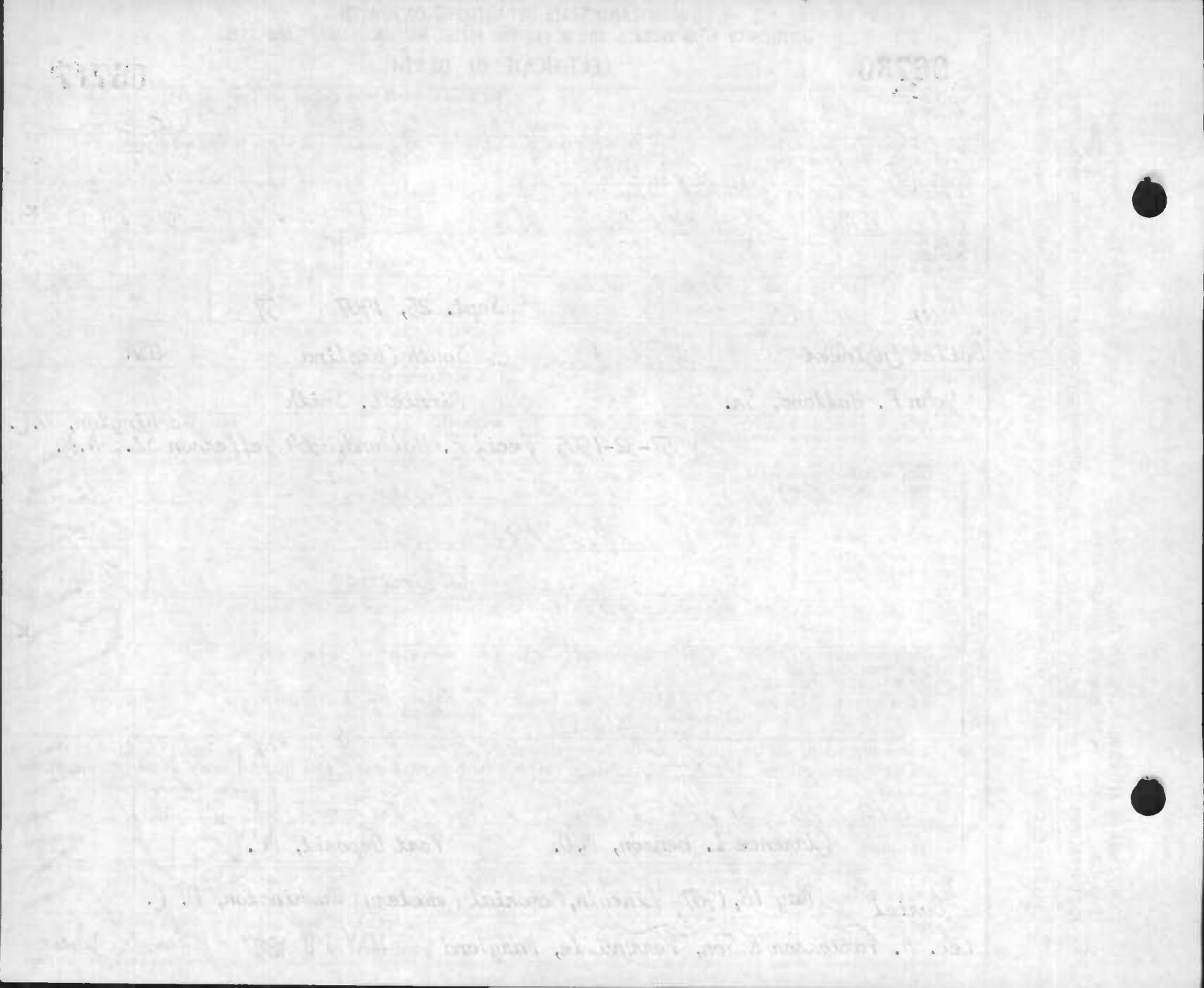
CERTIFICATE OF DEATH

06717

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE						
<i>Hanford</i> MARYLAND		Md						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb						
<i>Grace-de-Grace</i>		D.O.A.						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS						
<i>Hanford Memorial Hospital</i>		<i>Port Deposit</i> <i>38 Granite Ave</i>						
3. NAME OF DECEASED (Type or print)		First	Middle					
<i>John F</i>								
Last		4. DATE OF DEATH	Month					
<i>Holland</i>		5	13					
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Doy Year
<i>Male</i>		<i>Negro</i>	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	<i>Sept. 25, 1907</i>	<i>59 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done (Or most of working life, even if retired))		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>Bolter Engineer</i>		<i>Cint. Ser. Burnbridge</i>		<i>South Carolina</i>		<i>USA</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
<i>John F. Holland, Sr.</i>		<i>Minnie L. Smith</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>Washington, D.C.</i>		
		<i>557-32-1505</i>		<i>Cecil E. Holland, 8364 Jefferson St., N.E.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Cerebral Accident -		INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
<i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO		<i>Cerebral Atherosclerosis</i>		2 months		
		(c) DUE TO		<i>Atherosclerosis</i>		3 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 13, 1967</i> to <i>May 8, 1967</i> that (I) (we) last saw the deceased alive on <i>May 8, 1967</i> , and that death occurred at <i>5 P.M.</i> from causes and on the date stated above.								
22a. SIGNATURE <i>Clarence I. Benson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>May 13-67</i>				
22c. PHYSICIAN'S NAME (Type) <i>Clarence I. Benson, M.D.</i>		22d. ADDRESS <i>Port Deposit, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>May 18, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Lincoln Memorial Cemetery</i>		23d. LOCATION (City or Town) <i>Washington, D.C.</i>		
24. FUNERAL DIRECTOR <i>Lee A. Patterson &amp; Son</i>		ADDRESS <i>Perryville, Maryland</i>		25a. REC'D BY REGISTRAR <i>J Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		



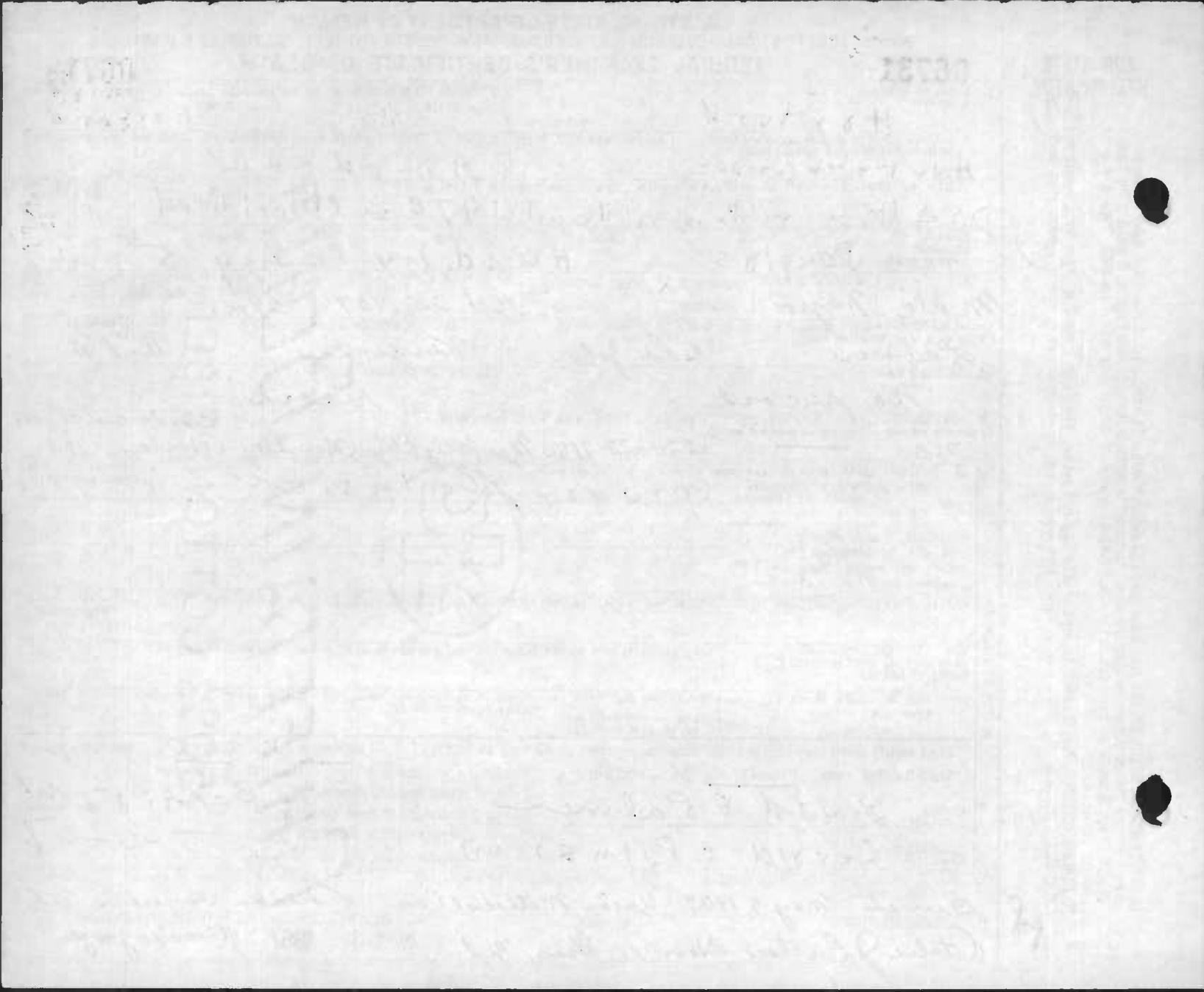
FOR STATE  
HEALTH DEPT.

(M)

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
06731				06718										
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE											
Hagerstown			Md.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			b. COUNTY											
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DPA Hospital/Memorial Hospital			d. STREET ADDRESS											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Douglass			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
Male Negro			WIOOWEO	Divorced	Hundley	Oct. 25, 1907	59 yrs.	5	1967					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Odd jobs			11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME No record			14. MOTHER'S MAIDEN NAME No record											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 224-22-7180			17. INFORMANT Mrs. Mary Eliza Hundley-Aberdeen, Md.			Address Box 470 Bush Chapel Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201			DUE TO (b)			CORONARY Oct 14 5, 1967			INTERVAL BETWEEN ONSET AND DEATH					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. underlying cause last.			DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work <input type="checkbox"/> at work <input type="checkbox"/>			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 5-6-67								
EXAMINER'S NAME (Type) Gerald E Palmer Address (Street, city, town, or county)														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 9, 1967			23c. NAME OF CEMETERY OR CREMATORIAL Union Methodist Cemetery			23d. LOCATION (City, town or county) Aberdeen, Maryland					
24. FUNERAL DIRECTOR Atelia J Bullock, Stereode Gray, Md.			ADDRESS			25a. REC'D BY REGISTRAR Mai 8			25b. REGISTRAR'S SIGNATURE Charles Judge					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06732

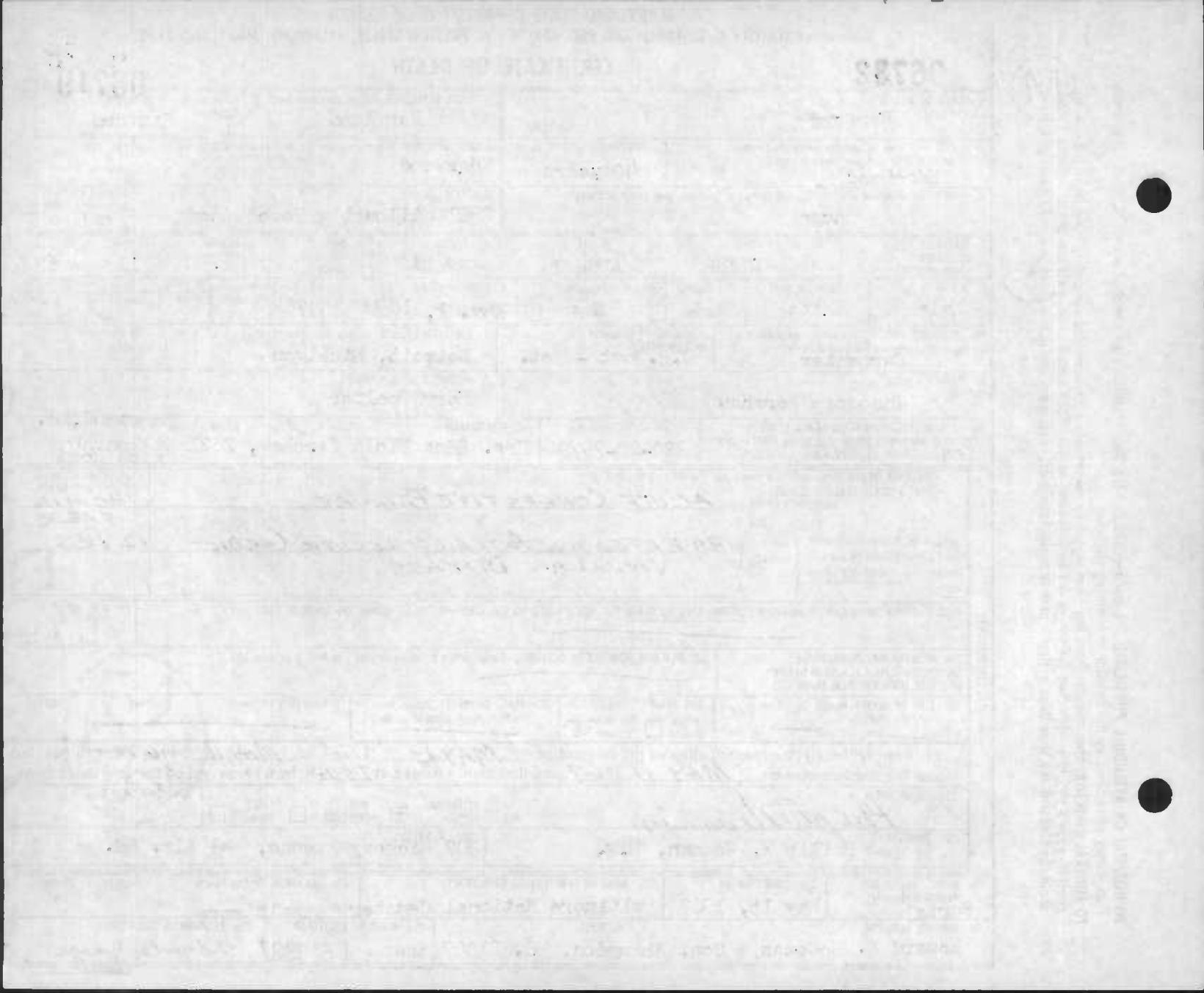
## CERTIFICATE OF DEATH

06719

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN lb 40 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle AUGUST Last KERSHAW		4. DATE OF DEATH Month May Day 11 Year 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 1, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		9. AGE (In years at birthday) 78 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt - Ret.		11. BIRTHPLACE (County & State, or foreign country) Detroit, Michigan	
13. FATHER'S NAME Theodore Kershaw		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 220-20-7979	
17. INFORMANT Mrs. Edna Viola Kershaw, 2821 Willoughby Beach Road		Address Edgewood, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 433X		INTERVAL BETWEEN ONSET AND DEATH 30 MIN OVER	
(b) HYPERTENSIVE ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (c)		12 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MAY 13, 1967 to MAY 11, 1967 that (I) (we) last saw the deceased alive on MAY 11, 1967, and that death occurred at 7:55 AM, from causes and on the date stated above.			
22a. SIGNATURE Philip W. Heuman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Philip W. Heuman, M.D.		22d. ADDRESS 307 Hickory Avenue, Bel Air, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 15, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		ADDRESS	
		25a. REC'D BY REGISTRAR DATE 15.11.15.1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

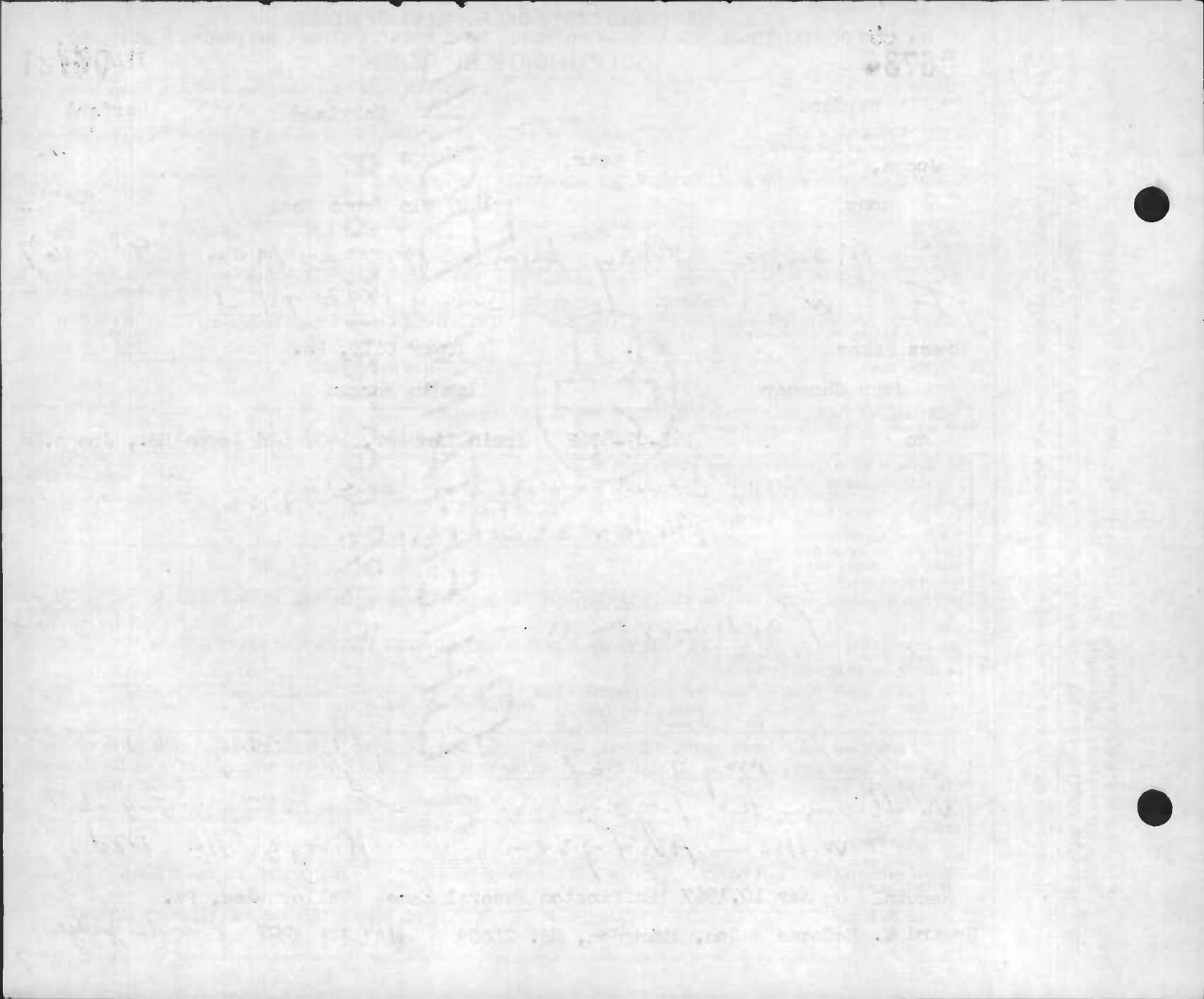
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Winston Thomas Kourrey</b>		First <b>Winston</b>	Middle <b>Thomas</b>	Lost <b></b>	4. DATE OF DEATH <b>May 3 1967</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/30/1927</b>	9. AGE (In years lost birthday) <b>39 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BALTO. TRANSIT CO. TRANSPORTATION</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>SALEM W. KOUREY</b>		14. MOTHER'S MAIDEN NAME <b>HELEN MEYER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-22-8165</b>		17. INFORMANT <b>DR. SALEM W. KOUREY (SAME)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Due to (b) _____ Due to (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Gerald C Palmer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Ber 4 1967</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>5-3-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/6/1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>	23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>	25a. REC'D BY REGISTRAR <b>MAI 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

3602

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												06721			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)													
a. COUNTY		Harford		a. STATE		Maryland		b. COUNTY		Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Joppa					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		none		d. STREET ADDRESS		1407 Old Joppa Road		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month	Day	Year			
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		WIDOWED		DIVORCED		June 4, 1892		74 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Dress Maker				Mfg.				Tower City, Pa.				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				Address							
John Shomper				Tammie Morgan				Irvin Limbert, 1407 Old Joppa Rd., Joppa, Md.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT															
(Yes, no, or unknown) (If yes give war or dates of service)				162-07-8362				17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular occlusion C															
DUE TO															
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) Arteriosclerosis				(c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Paroxysms —															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED while at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19															
21. I certify that (I) (this hospital) attended the deceased from Jan. 1967 to May 1967, that (I) (we) last saw the deceased alive on May 9 1967, and that death occurred at 103 <sup>rd</sup> St., from the causes and on the date stated above.															
22a. SIGNATURE William A. Tyson															
22b. DATE SIGNED 5-9-67															
22c. PHYSICIAN'S NAME (Type) William A. Tyson				M.D.		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF May 10, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Buffington Funeral Home		23d. LOCATION (City, town or county) Valley View, Pa.		(State)					
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009				ADDRESS		25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**06735**

**CERTIFICATE OF DEATH**

**08722**

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore de Grace</i>		c. LENGTH OF STAY IN 16 <i>35 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Litchens Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Edna</i>	Middle <i>Winkler</i>	Last <i>Maloney</i>
4. DATE OF DEATH	Month <i>May</i>	Day <i>14</i>	Year <i>1967</i>
5. SEX	6. COLOR OR RACE <i>Female White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>5/25/1893</i>
9. AGE (In years last birthday) <i>73 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wif</i>	11. KIND OF BUSINESS OR INDUSTRY <i>-</i>	12. BIRTHPLACE (Country & State, or foreign country) <i>Wilmington Del. U.S.A.</i>
13. FATHER'S NAME <i>Thomas P. Winkler</i>	14. MOTHER'S MAIDEN NAME <i>Edna G. Jones</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
16. SOCIAL SECURITY NO. <i>Link</i>		17. INFORMANT <i>Mrs. Lucy McMaster</i>	Address <i>800 S Washington St Baltimore Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Gastrointestinal Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Malignancy of G.I. tract</i>		2 - 3 months	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <i>A.s.C.V.D. and Nutritional Anemia + Hypofunctional</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Abingdon</i>
20f. (City or town) <i>Abingdon</i>	(County) <i>Del.</i>	(State) <i>Del.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>April 1st, 1967</i> to <i>May 13th, 1967</i> that (I) (we) last saw the deceased alive on <i>May 13th, 1967</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward C. Leonard</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Leonard</i>		22d. ADDRESS <i>Havre de Grace, Md.</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>5/17/67</i>	23b. DATE THEREOF <i>5/17/67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Quinton</i>	23d. LOCATION (City, town or county) <i>Wilmington Del.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington Pen, Havre de Grace, Md.</i>		ADDRESS <i>Pennington Pen, Havre de Grace, Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

26500

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

06736

**CERTIFICATE OF DEATH**

06723

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> <b>Burlington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b>		c. LENGTH OF STAY IN lb <b>N/A</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willingboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kirk Army Hospital</b>			d. STREET ADDRESS <b>16 Gamewell Lane</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>James D. MATTHEWS</b>		First <b>James</b>	Middle <b>D.</b>	Lost <b>MATTHEWS</b>	4. DATE OF DEATH <b>May 15, 1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>September 2, 1947</b>	9. AGE (In years lost birthday) <b>19 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	IF UNDER 24 HRS. Days <b>0</b>
13. FATHER'S NAME <b>James J. Matthews</b>			14. MOTHER'S MAIDEN NAME <b>Dorothy Anderson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>12 October 66-230-66-8322</b>	17. INFORMANT <b>DA 41 Personnel Records</b>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO stating the underlying cause last. (c) <b>Automobile Accident</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was a passenger in an auto involved in an accident.			
20c. TIME OF INJURY Month Day, Year Hour : am. <b>1:00</b> pm. <b>May 15, 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>JFK Hwy Rte 95</b>	20f. (City or town) <b>Whitemarsh, Baltimore, Md.</b>	(County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>15 May 1967</b> , to <b>15 May 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased <del>on</del> <b>DOA 15 May 1967</b> , and that death occurred at <b>2:00 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Thomas Fraher MD</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>15 May 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>THOMAS FRAHER, M.D.</b>		22d. ADDRESS <b>Kirk Army Hospital, APG, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>17 May 67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>St Marys Cemetery</b>	23d. LOCATION (City or Town) <b>Mt Holly, New Jersey</b>	(County) (State)
24. FUNERAL DIRECTOR <i>Wesley Walcocker Sr.</i>		ADDRESS <b>Tarring Funeral Home, Aberdeen, Md.</b>	25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE

66720

1965-1966  
1966-1967

1967-1968  
1968-1969

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1974-1975

1975-1976  
1976-1977

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1988-1989

1989-1990  
1990-1991

1991-1992  
1992-1993

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
06737				06724											
1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Harford</b>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b>				c. LENGTH OF STAY IN 1b <b>7 hours</b>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kirk Army Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>MARY</b>				First <b>L.</b>	Middle <b>MILLER</b>	Last <b>MAY</b>	4. DATE OF DEATH <b>19 February 1918</b>	Month <b>7</b>	Day <b>19</b>	Year <b>67</b>					
5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 February 1918</b>	9. AGE (in years (last birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR Months <b>11</b>	11. IF UNDER 24 HRS. Days <b>21</b>	12. Hours <b>11</b>	13. Min. <b>55</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress Cook Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurants</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Harford Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Edward Mathews</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Wolfgangton</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-01-9734</b>				17. INFORMANT <b>CLAUDE MILLER, Rt 3 Box 311, Aberdeen, Md.</b>				Address <b>311</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				DUE TO (b) <b>Hypertensive Cardiovascular Disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>THOMAS FRAHER, MD</b>				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7 May</b> , 19 <b>67</b> , to <b>7 May</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7 May</b> 19 <b>67</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.				22b. DATE SIGNED <b>7 May 67</b>											
22a. SIGNATURE <b>Thomas Fraher MD</b>				M.D. ATTENDING PHYS. <input type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) <b>THOMAS FRAHER, MD</b>				22d. ADDRESS <b>Kirk Army Hospital, APG, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10 May 67</b>				23c. NAME OF CEMETERY OR CREMATORIAL <b>Grove Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Aberdeen, Maryland</b>			
24. FUNERAL DIRECTOR <b>Charles J. Fraher</b>				Tarring ADDRESS <b>Aberdeen, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 10 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

1  
06738

**CERTIFICATE OF DEATH**

06725

1. PLACE OF DEATH

a. COUNTY

HARFORD

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

RORAL - ABERDEEN 21001

c. LENGTH OF STAY IN 1b

50 YRS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

R.D. #2 Box 308

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

MAY 18

1967

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

DEC. 16, 1885

9. AGE (In years  
last birthday)

81

yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

e. IS RESIDENCE  
ON A FARM?

YES  NO

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

FARM OWNER

11. BIRTHPLACE (County & State, or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S. A.

13. FATHER'S NAME

JAMES MILLER

14. MOTHER'S MAIDEN NAME

MARY BAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

—

16. SOCIAL SECURITY NO.

17. INFORMANT

Address: ABERDEEN 21001  
Mrs. HATTIE E MILLER R.D. #2 Box 308

INTERVAL BETWEEN  
ONSET AND DEATH

plus

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

42201

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Acute Congestive Cardiac Failure  
Advance of Arterio sclerotic CV Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Ch. cholesteric Festu

19. WAS AUTOPSY PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While Not While  
at work  at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1967, to May 17, 1967, that (I) (we) last saw the deceased alive on May 17, 1967, and that death occurred at 2A M, from the causes and on the date stated above.

22a. SIGNATURE

R. Lynn Holley

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

5/19/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

Churchville MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

May 20, 1967

23c. NAME OF CEMETERY OR CREMATORI

WESLEYAN CHAPEL

23d. LOCATION (City, town or county)

Em. HARFORD Co.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

R. Madison Mitchell, NAVIRE DE GRACE

ADDRESS

25a. REC'D BY REGISTRAR

MAY 22, 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

18

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06733

## CERTIFICATE OF DEATH

06726

13  
1. PLACE OF DEATH  
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2

Edgewood Arsenal, Md.

c. LENGTH OF STAY IN 1b  
approx. 6 hrs.

on 28 May 67

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

USA Dispensary, Edgewood Arsenal

## 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore Co.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore, Maryland 21215

## d. STREET ADDRESS

2817 Ruscombe Lane

## e. IS RESIDENCE ON A FARM?

YES  NO 3. NAME OF DECEASED  
(Type or print)

First Kenneth

Middle Joseph

Last Millhoff

4. DATE OF DEATH  
May 28  
Month Day Year  
19 67

## 5. SEX

Male

## 6. COLOR OR RACE

Cau

## 7. MARRIED

 NEVER MARRIED 

## WIDOWED

## DIVORCED

## 8. DATE OF BIRTH

May 7, 1945

## 9. AGE (In years last birthday)

22 yrs.

## 10. IF UNDER 1 YEAR

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chemical Engineer

## 10b. KIND OF BUSINESS OR INDUSTRY

Fed. Civ. Svc.

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Baltimore Co., Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

David Millhoff

## 14. MOTHER'S MAIDEN NAME

Florence Fischer

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

---

## 16. SOCIAL SECURITY NO.

214-44-6561

## 17. INFORMANT

(Uncle) Robert Fischer, Baltimore, Md.

Address

INTERVAL BETWEEN  
DNSET AND DEATH

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)9319  
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.

Heat stroke

DUE TO

(b)

Thermal control failure

DUE TO

(c)

Environmental heat

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?  
YES  NO 

## 20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 1920d. INJURY OCCURRED  
While at work  Not While at work 

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 21 August 1966, to 28 May 1967, that (II) (we) last saw the deceased alive on 28 May 1967, and that death occurred at M, from the causes and on the date stated above.

## 22a. SIGNATURE

Ernest N. Moss, M.D.  
22b. DATE SIGNED  
27 June 196722c. PHYSICIAN'S NAME (Type)  
ERNEST N. MOSS, LTC, MC USA Dispensary, Edgewood Arsenal23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial23b. DATE THEREOF  
29 May 196723c. NAME OF CEMETERY OR CREMATORIUM  
Tifereth Israel Anshe Sfard

## 23d. LOCATION (City, town or county) (State)

Rosedale (Balto. Co.) Md.

## 24. FUNERAL DIRECTOR

Sol Levinson & Bros. 6010 Reisterstown Rd.  
Baltimore, Maryland

## 25a. REC'D BY REGISTRAR

DATE JUN 30 1967

## 25b. REGISTRAR'S SIGNATURE

Charles Judge

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT

M



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

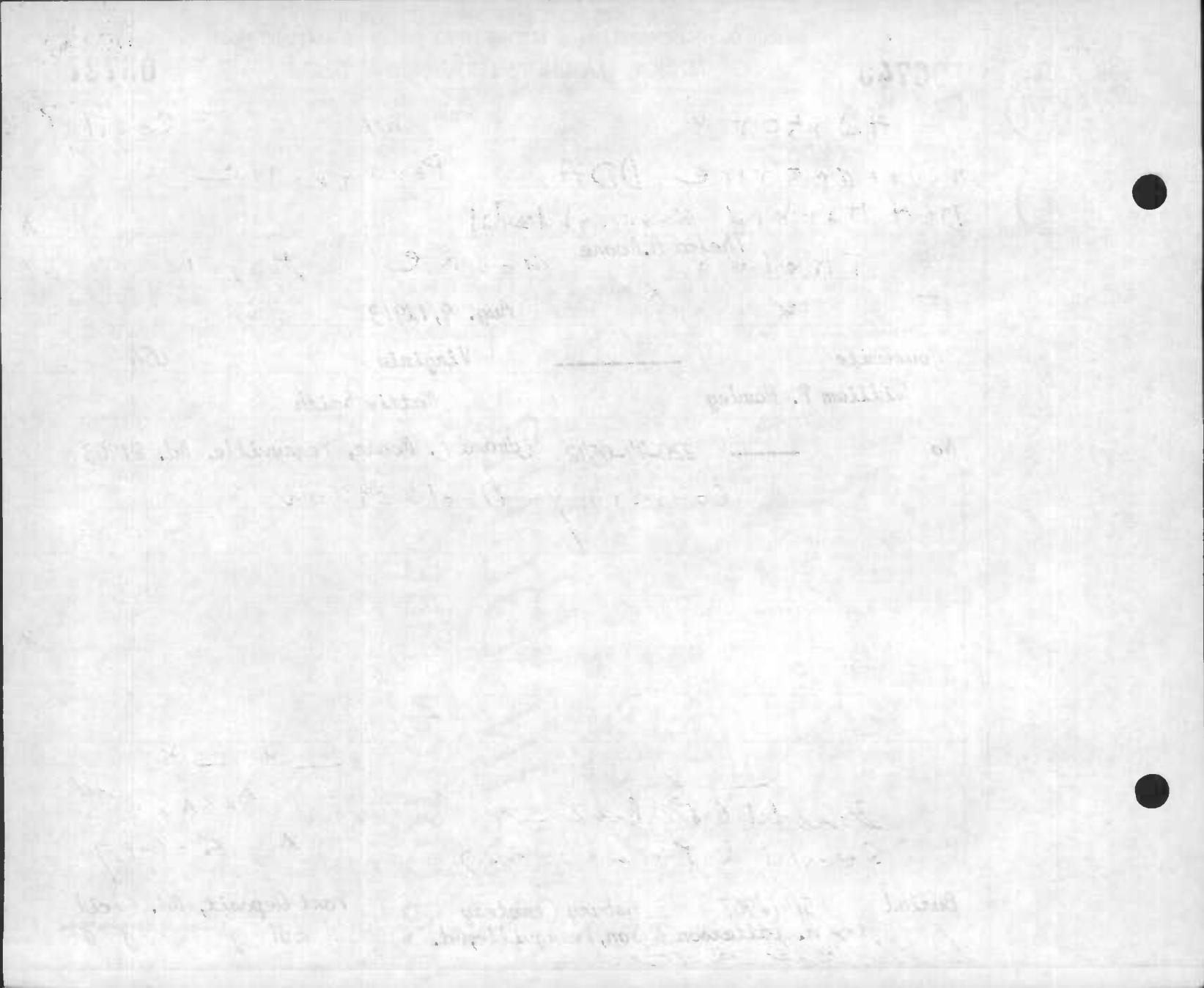
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06727

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		
Harford MARYLAND			Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace DDA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dart Harford Memorial Hospital			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
Thelma A. Moore			Month	Day	Year
5. SEX			Lost		
F			6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH
W			<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> WIDOWED	Aug. 9, 1913
100. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife			9. AGE (In years lost birthday) 53 yrs.		
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William P. Hawley			Mattie Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 220-44-0542		
17. INFORMANT			Address Edward E. Moore, Perryville, Md. 21903		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>			INTERVAL BETWEEN ONSET AND DEATH		
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO _____ last _____ DUE TO _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.					
EXAMINER'S NAME (Type) <i>Gerald C Palmer - MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/4/1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Asbury Cemetery</i>	
24. FUNERAL DIRECTOR <i>Lee A. Patterson &amp; Son, Perryville, Md.</i>		ADDRESS		23d. LOCATION (City or Town) (County) (State) <i>Port Deposit, Md. Cecil</i>	
25. REC'D BY REGISTRAR <i>K. J. ...</i>		DATE <i>1967</i>		25b. REC'D BY CLERK <i>Charles J. George</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dep't. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**06741**

**06728**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Hartford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Harford Grace</i>		c. LENGTH OF STAY IN lb <i>95 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>R.D. # 2 Bay 21078</i>		e. STREET ADDRESS <i>R.D. # 2 Bay</i>	
3. NAME OF DECEASED (Type or print) <i>George L.</i>		4. DATE OF DEATH <i>Osborn</i>	Month <i>May</i> Day <i>27</i> Year <i>1967</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 20 1871</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>George V. Osborn</i>		14. MOTHER'S MAIDEN NAME <i>Martha Margaret Thompson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-30-3880</i>	17. INFORMANT <i>Mrs. Corinna S. Hines Harford Grace Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4232</i>		<i>Cardiac Insufficiency</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) DUE TO (c)		<i>Myocarditis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	2Da. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1940</i> , 19..., to <i>5-27-67</i> , that (I) (we) last saw the deceased alive on <i>5-26-67</i> and that death occurred at ..... M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>Q. L. Osborn MD</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <i>Q. L. Osborn MD</i>		22d. ADDRESS <i>Harford Co. Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 29 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Wesleyan Chapel Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Harford Co. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell, Harford Grace Md.</i>		ADDRESS <i>101 Main St. Harford Grace Md.</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 31 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1153

**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06742

**CERTIFICATE OF DEATH**

06729

1. PLACE OF DEATH a. COUNTY <b>Harford</b>  MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>  b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Grounds</b>		c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Grounds</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kirk Army Hospital</b>		d. STREET ADDRESS <b>2728 C West Court St.</b>	
e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Janet</b>	Middle <b>M</b>	4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 Aug 64</b>
9. AGE (In years lost at death) <b>2 yrs.</b>	10. IF UNDER 1 YEAR Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min. <b>9</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co., Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William A. PAPES</b>	14. MOTHER'S MAIDEN NAME <b>Margaret Fischer</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mother, Same as 2 C &amp; D</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neuroblastoma, metastatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO last (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>11691 PM</b> (State) <b>Maryland</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>13 May</b> , 1967, to <b>13 May</b> , 1967, that (I) (we) last saw the deceased alive on <b>13 May</b> , 1967, and that death occurred at <b>11:09 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Leland W. Wight Jr. M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>13 May 67</b>
22c. PHYSICIAN'S NAME (Type) <b>Leland W. Wight Jr. M.D.</b>		22d. ADDRESS <b>Aberdeen Proving Ground, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/16/1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arlington National Cemetery Ft. Meyer, Va.</b>
24. FUNERAL DIRECTOR <b>Tarring Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

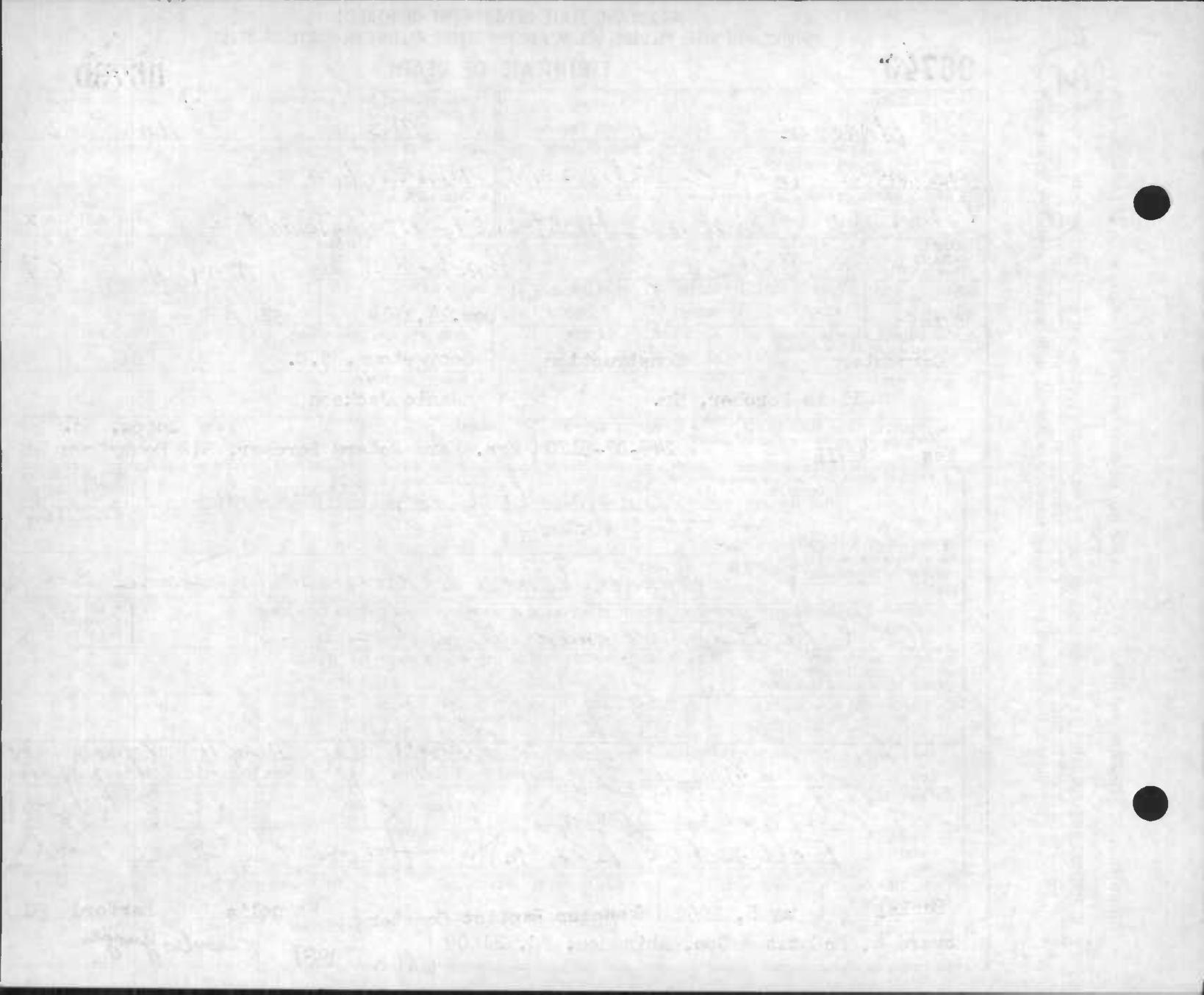
06743

**CERTIFICATE OF DEATH**

06730

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harfard</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hause de Grace</i>		c. LENGTH OF STAY IN 1b <i>2 hrs 30 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Magnolia</i>		d. STREET ADDRESS <i>512 Dembytown Rd.</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Willie</i>		First	Middle	Last	4. DATE OF DEATH <i>Porcher</i>	Month <i>May</i>	Day <i>4</i>	Year <i>1967</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Dec. 14, 1914</i>	9. AGE (In years last birthday) <i>52 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS. Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Georgetown, S.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Willie Porcher, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Janie Jackson</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>249-07-5170</i>		17. INFORMANT <i>Mrs. Mary Peters Porcher, 512 Dembytown Rd</i>		Address <i>Joppa, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Extensive Anterior Coronary Thrombosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerotic Cardiovascular Disease 3-4 yrs</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Old Posterior Coronary Thrombosis</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>119</i>		20f. (City or town) <i>Harford</i>	(County) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>May 1, 1966</i> to <i>May 4, 1967</i> that (I) (we) last saw the deceased alive on <i>May 4, 1967</i> , and that death occurred at <i>119</i> M, from causes and on the date stated above.								
22a. SIGNATURE <i>Edward C. Loo</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/4/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo MD</i>		22d. ADDRESS <i>Hause de Grace, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 8, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ebenezer Baptist Cemetery</i>		23d. LOCATION (City or town) <i>Magnolia</i>		
24. FUNERAL DIRECTOR <i>Howard K. McComas &amp; Son, Abingdon, Md. 21009</i>		ADDRESS <i>2500</i>		RECD. BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		





**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

06744      05731

1. PLACE OF DEATH e. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>		c. LENGTH OF STAY IN lb <b>5 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Old Fallston Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Heidi</b>	Middle <b>-----</b>	Last <b>QUESENBERY</b>
4. DATE OF DEATH Month <b>May</b>	Day <b>25,</b>	Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1962</b>
9. AGE (In years last birthday) <b>4 yrs.</b>	10. IF UNDER 1 YEAR Months <b>-----</b>	11. IF UNDER 24 HRS. Days <b>-----</b>	12. IF UNDER 24 HRS. Hours <b>-----</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maricopa Co., Arizona</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lonnie Ray Quesinberry, Jr.</b>	
14. MOTHER'S MAIDEN NAME <b>Ruth Ann Pierce</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT (Father) <b>838-9245</b> , P.O. Box #6321047 <b>Mr. L. Ray Quesinberry, Jr. Fallston, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (e) <b>1930</b> DUE TO <b>Cerebral Neoplasm, Malignant</b>			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. (b)      DUE TO (c)      DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (Ie)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 1967</b> to <b>5/25/1967</b> , that (I) (we) last saw the deceased alive on <b>5/25/1967</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.			
22e. SIGNATURE <b>Kermit P. Bonovich</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.	22b. DATE SIGNED <b>May 25, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Kermit P. Bonovich M.D.</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>879-0717</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mountain Christian Ch. Cemetery Joppa, Harf. Co., Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph William Foster</b>		25a. REC'D BY REGISTRAR DATE <b>May 29 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M  
06745MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06732

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Penna.</b> b. COUNTY <b>York</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pylesville</b>		c. LENGTH OF STAY IN lb <b>3 Mos.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Violet Viatrice Roberts</b>		First      Middle      Lost	4. DATE OF DEATH <b>May 1, 1967</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/12/1910</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years lost birthday) <b>56 yrs.</b>	
13. FATHER'S NAME <b>Luther Perkins</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-54-2975</b>	17. INFORMANT Address <b>Mrs. Marie Measley, Pylesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>generalized Carcinomatosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1965 May 1, 1967</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, to _____, that (I) (we) last saw the deceased alive on <i>May 1, 1967</i> , and that death occurred at <i>5:20 PM</i> , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <i>Doris Abbott</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5/2/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Doris Abbott MD</i>		22d. ADDRESS <i>Delta, Pa.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/4/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Norrisville</b>	23d. LOCATION (City or Town) (County) (State) <b>Norrisville, Harford Co. Md.</b>
24. FUNERAL DIRECTOR <i>Zenith W. Oberly</i>		ADDRESS <b>Stewartstown, Pa.</b>	25a. RECEIVED BY REGISTRAR <b>MAY 4 1967</b>	25b. DIRECTOR'S SIGNATURE <i>Charles Judge</i>

64730

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152	1153	1154	115

FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

1  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06746

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06733

1. PLACE OF DEATH o. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		d. STREET ADDRESS ( <b>WHEEL Road</b> ) <b>Route 3, Box 335</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>CHARLES</b>	Middle <b>FREDERICK</b>	Lost	4. DATE OF DEATH	Month <b>May</b>	Doy <b>29</b>	Year <b>1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1948</b>	9. AGE (In years lost birthday) <b>18 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Dys Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TREE TRIMMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Asplundh Tree Exp. Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore City, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>William DENNIS Sanders</b>	14. MOTHER'S MAIDEN NAME <b>Grace Taylor</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>218-50-6177</b>	17. INFORMANT (mother) <b>838-9238</b> Address <b>RFD #3, Box # 335 Mrs. Grace T. Sanders Bel Air, Maryland 21014</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9705</b> Salicylate Overdose DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO _____ lost (c) _____	INTERVAL BETWEEN ONSET AND DEATH
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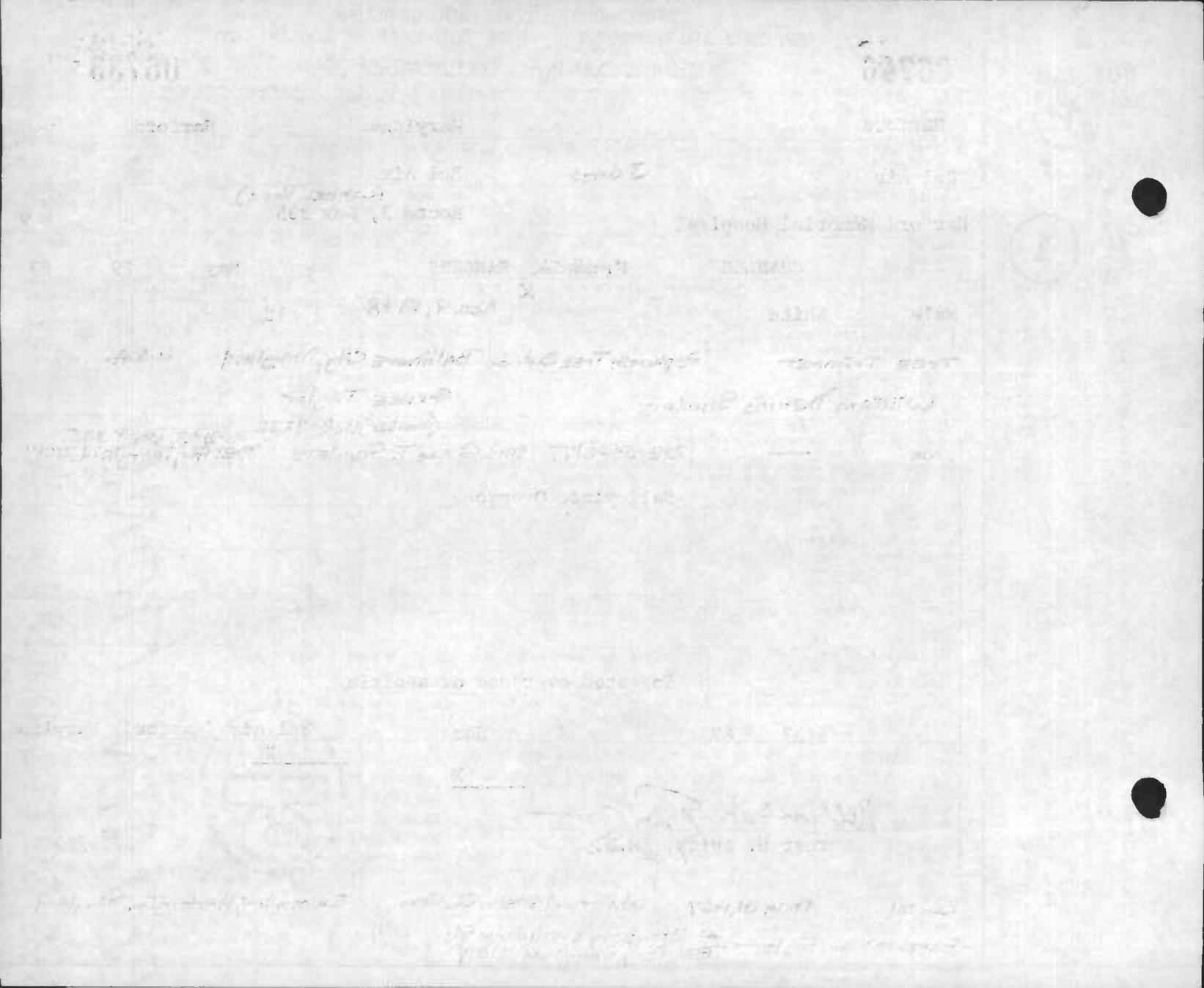
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingested overdose of aspirin</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Bel Air (Harford)</b> (County) <b>Maryland</b> (State)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>5/27 19 67</b>			

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	22. DATE SIGNED <b>5/29/67</b>
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ACTUAL SIGNATURE <b>Werner U. Spitz</b>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	Address (Street, city, town, or county) <b>Emmorton, Harford Co., Maryland</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Carmel Meth. Ch. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Emmorton, Harford Co., Maryland</b>
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>	ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>	25a. REC'D BY REGISTRAR <b>JUN 1 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

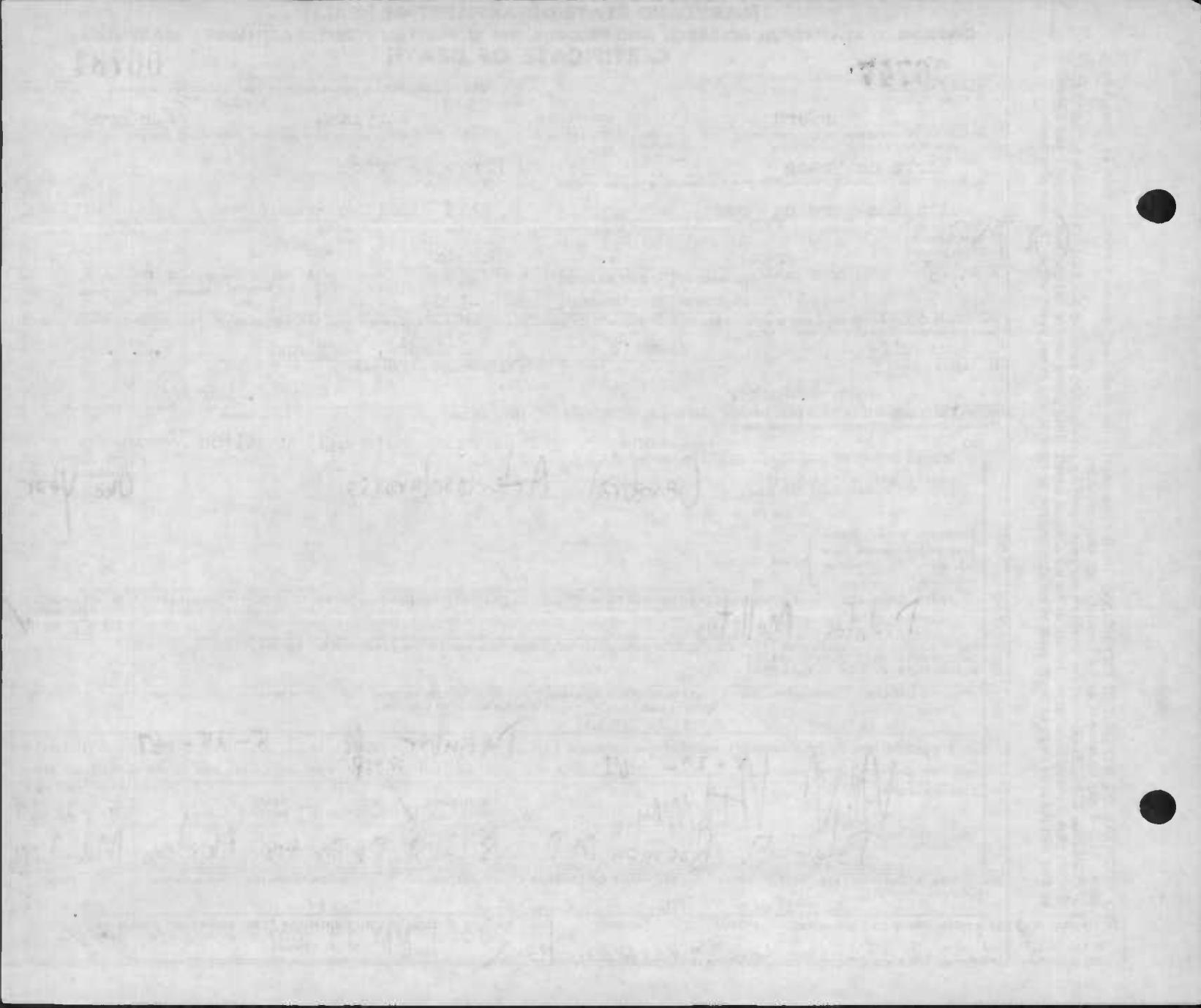
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

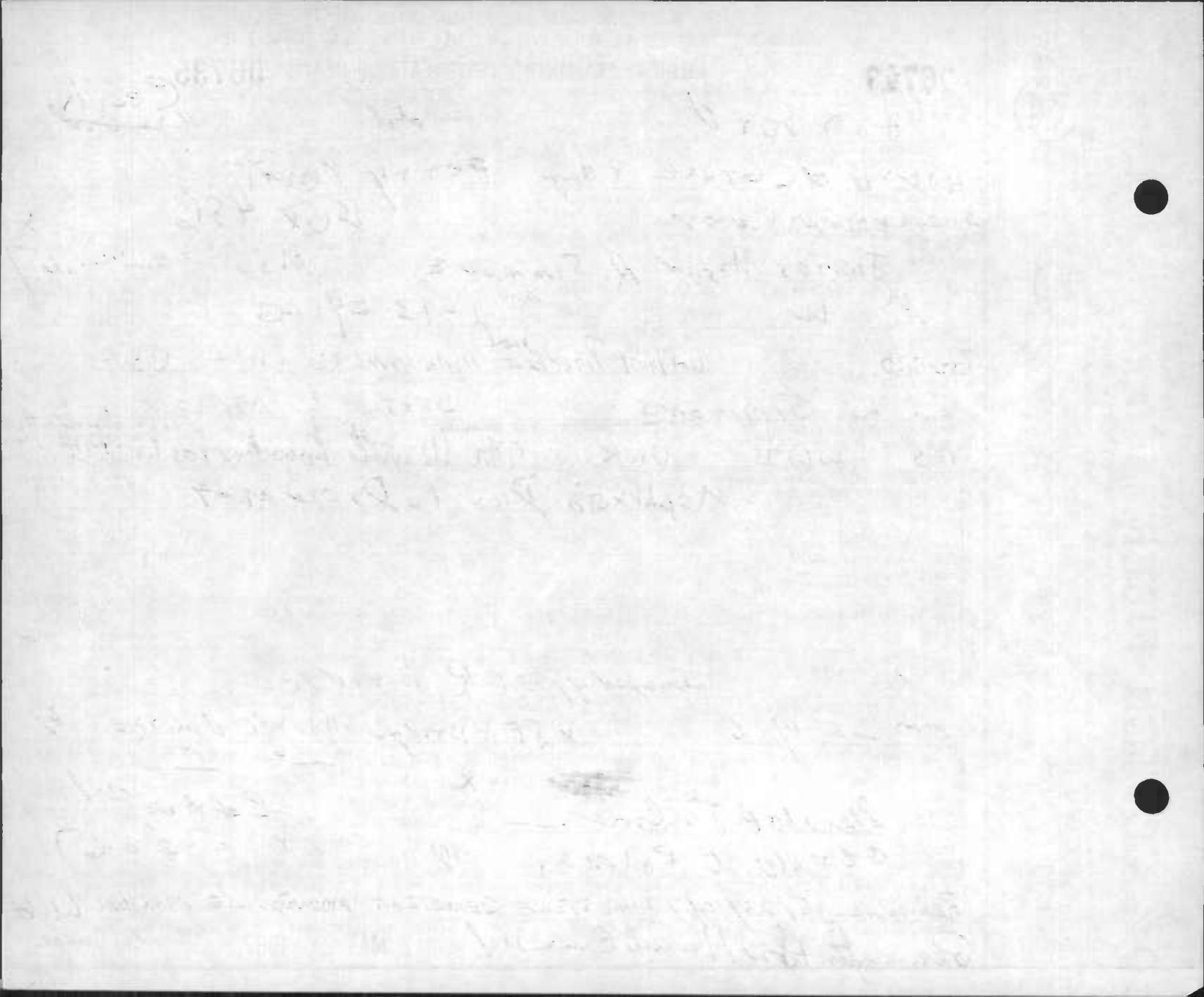
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached from use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 26747		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY <b>Harford</b>		e. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harve de Grace</b>		b. COUNTY <b>Harford</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Citizens Nursing Home</b>		d. STREET ADDRESS <b>4113 Hamilton Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Marie</b>		First <b>R.</b>	Middle <b>Schutz</b>
4. DATE OF DEATH <b>5 25 1967</b>		Lesl	Month Dey Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>8-12-1903</b>		9. AGE (In years last birthday) <b>63 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John R. Hecker</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Murphy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr Norval Schutz</b>		Address <b>4113 Hamilton Avenue #6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <b>General</b>		INTERVAL BETWEEN ONSET AND DEATH <b>One year</b>	
DUE TO <b>334X</b>		DUE TO <b>Arteriosclerosis</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b>		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>8 Law St., P.O. Box 548, Aberdeen, Md. 21001</b>
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 1966</b> , to <b>5-25-1967</b> , that (I) (we) last saw the deceased alive on <b>5-23-1967</b> , and that death occurred at <b>5:05 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>5-26-67</b>	
22e. SIGNATURE <b>V. T. Mann</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>		22d. ADDRESS <b>8 Law St., P.O. Box 548, Aberdeen, Md. 21001</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Parkwood Cemetery</b>	
23b. DATE THEREOF <b>5-27-1967</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home 7401 Adam Road</b>		25a. REGD BY REGISTRAR DATE <b>MAY 31 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	







## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96748

## CERTIFICATE OF DEATH

06736

**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>3 WEEKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEL AIR</b>		d. STREET ADDRESS <b>Apt # 33 126 Hickory AVENUE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BREVIN Nursing Home</b>				d. DATE OF DEATH <b>MAY 1, 1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>GEORGE</b>	Middle <b>Albert</b>	Last <b>Simon</b>	4. DATE OF DEATH <b>MAY 1, 1967</b>	Month Year	Day	Year
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 22, 1882</b>	9. AGE (In years lost birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Simon</b>				14. MOTHER'S MAIDEN NAME <b>L. Elizabeth WEAVER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>716-09-4931</b>		17. INFORMANT (wife) <b>838-3655</b> Address <b>Mrs. Elizabeth P. Simon 126 Hickory Ave. Apt. 33 Bel Air, Maryland 21014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) <b>Pyelonephritis</b> <b>1.5 days</b> DUE TO stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>old age</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>(injury)</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1967</b> to <b>4-30, 1967</b> , that (I) (we) last saw the deceased alive on <b>4-30 1967</b> , and that death occurred at <b>7:30 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>John D. Y.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 1, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>John D. Y. M.D.</b>		22d. ADDRESS <b>615 S. Union Ave, Havre de Grace, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Spring Episcopal Ch. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Forest Hill, Harford Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		ADDRESS <b>W. Broadway &amp; Williams St. BEL AIR, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
VR A15 (4) 20 M 1/66		DATE MAY 2 1967					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06737

26750

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of the death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>HARFORD</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAUKE &amp; LORANCE</b>		c. LENGTH OF STAY IN lb <b>57 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abingdon</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>HARRY</b>		First <b>A</b>	Middle <b></b>	Lost <b></b>	4. DATE OF DEATH <b>Smith</b>	Month <b>MAY</b>	Day <b>13</b>	Year <b>1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1903</b>	9. AGE (In years last birthday) yrs. <b>63</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS Days <b></b>	12. IF UNDER 24 HRS Hours <b></b>	Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cable Splicer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Govt - Ret.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Harry Gregory Smith</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1928-1940</b>		17. INFORMANT <b>Mrs. Katherine I. Smith, 4004 Phila Rd.</b>		Address <b>Abingdon, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>						<b>3 days</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic CV Disease</b>		DUE TO (b) <b>Diabetes Mellitus</b>				<b>8 yrs</b>		
DUE TO (c)						<b>28 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May 13, 1967</b> to <b>May 13, 1967</b> that (I) (we) last saw the deceased alive on <b>May 13, 1967</b> and that death occurred at <b>6:05 AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Ralph Harky MD</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <b>Ralph Harky MD</b>		22d. ADDRESS <b>Churchville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Bel Air Harford Md</b>		
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAT 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

Tested and found  
no evidence of  
infection

Specimen sent to Dr. MD  
for further examination

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06751

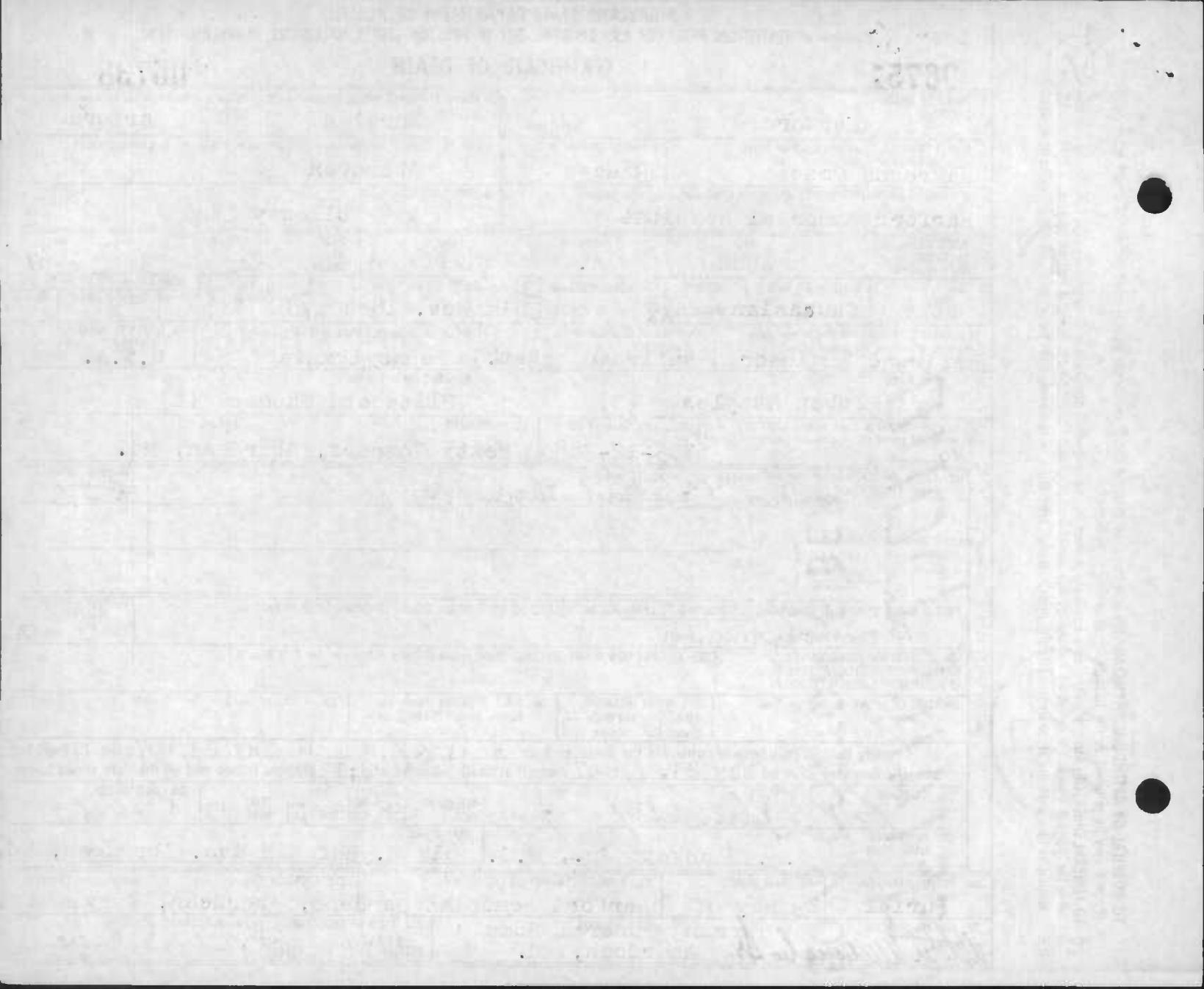
## CERTIFICATE OF DEATH

06738

**To HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

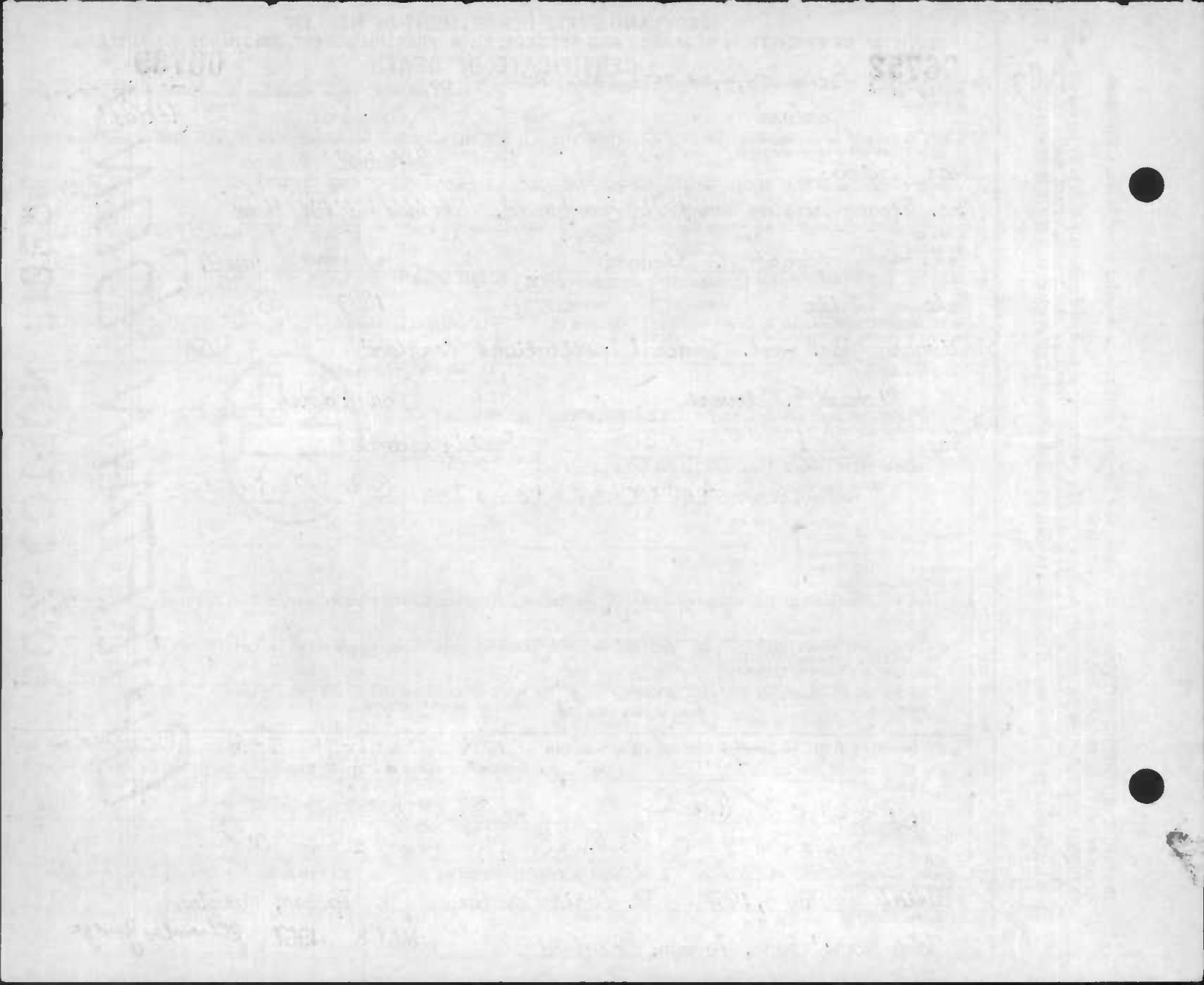
1. PLACE OF DEATH o. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>A.</b>	4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>14 Nov. 1888</b>	
9. AGE (In years last birthday) <b>78 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Engineer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad (Ret.)</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Reuben Staples (D)</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Thomas (D)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>705-12-7880</b>	17. INFORMANT <b>Betty Gompers, Aberdeen, Md.</b>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Bronchopneumonia</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>May 23, 1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-15-67</b> , 19 <b>67</b> , to <b>May 23, 1967</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>May 23, 1967</b> , and that death occurred at <b>8:17 AM</b> from causes and on the date stated above.				
22a. SIGNATURE <b>S J Plunkett Jr.</b>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>5-24-67</b>
22c. PHYSICIAN'S NAME (Type) <b>B.J. Plunkett Jr., M.D.</b>	22d. ADDRESS <b>617 W. Bel Air Ave. Aberdeen, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>29 May 67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Harford Memorial Gardens, Aberdeen, Maryland</b>	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Tarrin Funeral Home</b>	ADDRESS <b>Aberdeen, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>MAY 26 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Harford</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>				b. COUNTY <i>Harford</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Near Edgewood</i>				c. LENGTH OF STAY IN 1D <i>1</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belvedere / Towson</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>(Mrs. Strong Nursing Home) Old Emorton Rd.</i>				d. STREET ADDRESS <i>Shealey Ave. St. Johns Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Edward A. Steuart</i>				First	Middle	Last	4. DATE OF DEATH DF DEATH <i>May 4, 1965</i>	Month	Day	Year			
5. SEX <i>Male</i>				6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1883</i>	9. AGE (in years last birthday) <i>83 yrs.</i>	10. UNDER 1 YEAR Months <i>83</i>	11. UNDER 24 HRS. Hours <i>03</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stationery Ingr. - ret.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>General Institutions</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>					
13. FATHER'S NAME <i>Richard S. Steuart</i>				14. MOTHER'S MAIDEN NAME <i>Mary Bosley</i>				Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>441-11-1111</i>				17. INFIRMITY <i>Family records</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic CV Disease</i>   INTERVAL BETWEEN ONSET AND DEATH 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>1-1, 1965</i> , to <i>5-4, 1967</i> , that (I) (we) last saw the deceased alive on <i>4-1, 1967</i> , and that death occurred at <i>6A M</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>Gerald E. Palmer</i>				22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <i>Gerald E. Palmer, M.D.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Bel Air - Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>May 6, 1967</i>				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Mt. Maria Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Towson, Maryland</i>	
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>								25a. REC'D BY REGISTRAR DATE <i>MAY 8 1967</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

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**CERTIFICATE OF DEATH**

06740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b>		c. LENGTH OF STAY IN lb <b>2 Hours</b>		b. COUNTY <b>Burlington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kirk Army Hospital</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverside</b>		
3. NAME OF DECEASED (Type or print) <b>Patrick J. STOER</b>			d. STREET ADDRESS <b>512 Monroe Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 30, 1947</b>	9. AGE (In years lost birthday) <b>19 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>	
13. FATHER'S NAME <b>Benjamin Stoer</b>			14. MOTHER'S MAIDEN NAME <b>Loretta McCay</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>12 Oct 66</b>			16. SOCIAL SECURITY NO. <b>136-40-1755</b>		17. INFORMANT <b>DA 41 Personnel Records</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries to head</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 Hours</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>8834</b>			DUE TO (b) <b>intra-thoracic organs and intra-abdominal organs</b>		
			DUE TO (c) <b>Automobile Accident</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Deceased was the driver of an auto involved in an accident.</b>			
20c. TIME OF INJURY Month Day, Year Hour o.m. <b>1:00</b> p.m. <b>May 15 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>JFK Hwy Rte 95</b>	
20f. (City or town) <b>Whitemarsh</b> (County) <b>Baltimore, Md.</b> (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 15</b> , 19 <b>67</b> , to <b>May 15</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 15</b> 19 <b>67</b> , and that death occurred at <b>4:00 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Thomas Fraher MD</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <b>THOMAS FRAHER, M.D.</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>15 May 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS FRAHER, M.D.</b>		22d. ADDRESS <b>Kirk Army Hospital, APG, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 19, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Beverly National Cemetery</b>	
23d. LOCATION (City or Town) <b>Beverly</b> (County) <b>New Jersey</b> (State)					
24. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
25b. REC'D BY REGISTRAR <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>		DATE <b>MAY 19 1967</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06754

CERTIFICATE OF DEATH

06741

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Cecil</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de Grace</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hosp</b>		d. STREET ADDRESS <b>1087 Ave D.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Posey Grover Sumpter</b>		First	Middle	Last	4. DATE OF DEATH	Month	Doy	Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30, 1890</b>	9. AGE (In years lost birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aberdeen Prov. Gnd.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Joseph G. Sumpter</b>		14. MOTHER'S MAIDEN NAME <b>Martha Allie</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>716-01-8655</b>		17. INFORMANT <b>Mrs. Maggie M. Sumpter, Perry Point, Md.</b>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>		20 days								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arterio sclerosis</b>		5 yrs								
DUE TO (c) <b>And ASCVD</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20c. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>May 10</b> 1967 P.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>DARLINGTON</b>		(County) <b>St. Mary's</b>	(State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>May 10</b> , 1967, to <b>May 12</b> , 1967, that (I) (we) last saw the deceased alive on <b>May 12</b> , 1967 and that death occurred at <b>6:30 AM</b> , from causes and on the date stated above.										
22c. PHYSICIAN'S NAME (Type) <b>Dudley Phillips MD</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>DARLINGTON, Md.</b>		22e. DATE SIGNED <b>5/12/67</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Asbury Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Port Deposit, Maryland.</b>				
24. FUNERAL DIRECTOR <b>J. Patterson &amp; Son</b>						25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>				
Lee A. Patterson & Son, Perryville, Maryland.						25b. REGISTRAR'S SIGNATURE				
						DATE <b>MAY 19 1967</b>				

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06755

**CERTIFICATE OF DEATH**

06742

**1. PLACE OF DEATH**

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hare-De-Grace

c. LENGTH OF STAY IN lb

3 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Hartford Memorial Hospital

**3. NAME OF DECEASED**  
(Type or print)

First  
Lillian C

Middle  
Teyhan

Last

**2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)**

a. STATE

Md

b. COUNTY

Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bel Air

BEL AIR

Box #14

d. STREET ADDRESS

N. Ridge Rd. R.D #2

1801

e. IS RESIDENCE ON A FARM?

YES  NO

**5. SEX**

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

4. DATE OF DEATH

Month  
Feb  
Year  
1967

Month  
5

Day  
31

Year  
1967

100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Insurance

9. AGE (In years lost birthday)

62 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Doys

Hours

Min.

13. FATHER'S NAME

John R. Culp

14. MOTHER'S MAIDEN NAME

Laura Alice Hefley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

250-34-3981

17. INFORMANT Husband

832-7668

Address

North Ridge Drive

Rebel Road #14, Cedar Lane

BEL AIR, Maryland 21014

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4201

Due To

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Due To

(c)

Due To

Myocardial infarction

INTERVAL BETWEEN ONSET AND DEATH

4-6 hrs.

Coronary thrombosis

4-6 hrs.

Arteriosclerotic Cardiovascular Disease 3 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED?

YES  NO

**MEDICAL CERTIFICATION**

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20d. INJURY OCCURRED  
While  Not While   
at work  at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 29, 1967 to May 31, 1967, that (I) (we) last saw the deceased alive on May 31, 1967, and that death occurred at 4:30 P.M. from causes and on the date stated above.

22b. DATE SIGNED

5/31/67

22c. SIGNATURE

Edward C. Loo, M.D.

M.D. ATTENDING PHYS

MED. DIRECTOR

STAFF PHYS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City or Town) (County) (State)

Burial

Bel Air Memorial Gardens

Bel Air, Harford Co., Maryland 21014

23b. DATE THEREOF

ADDRESS

23e. REC'D BY REGISTRAR

JUNE 2, 1967

W. Broadway & Williams St.

23b. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

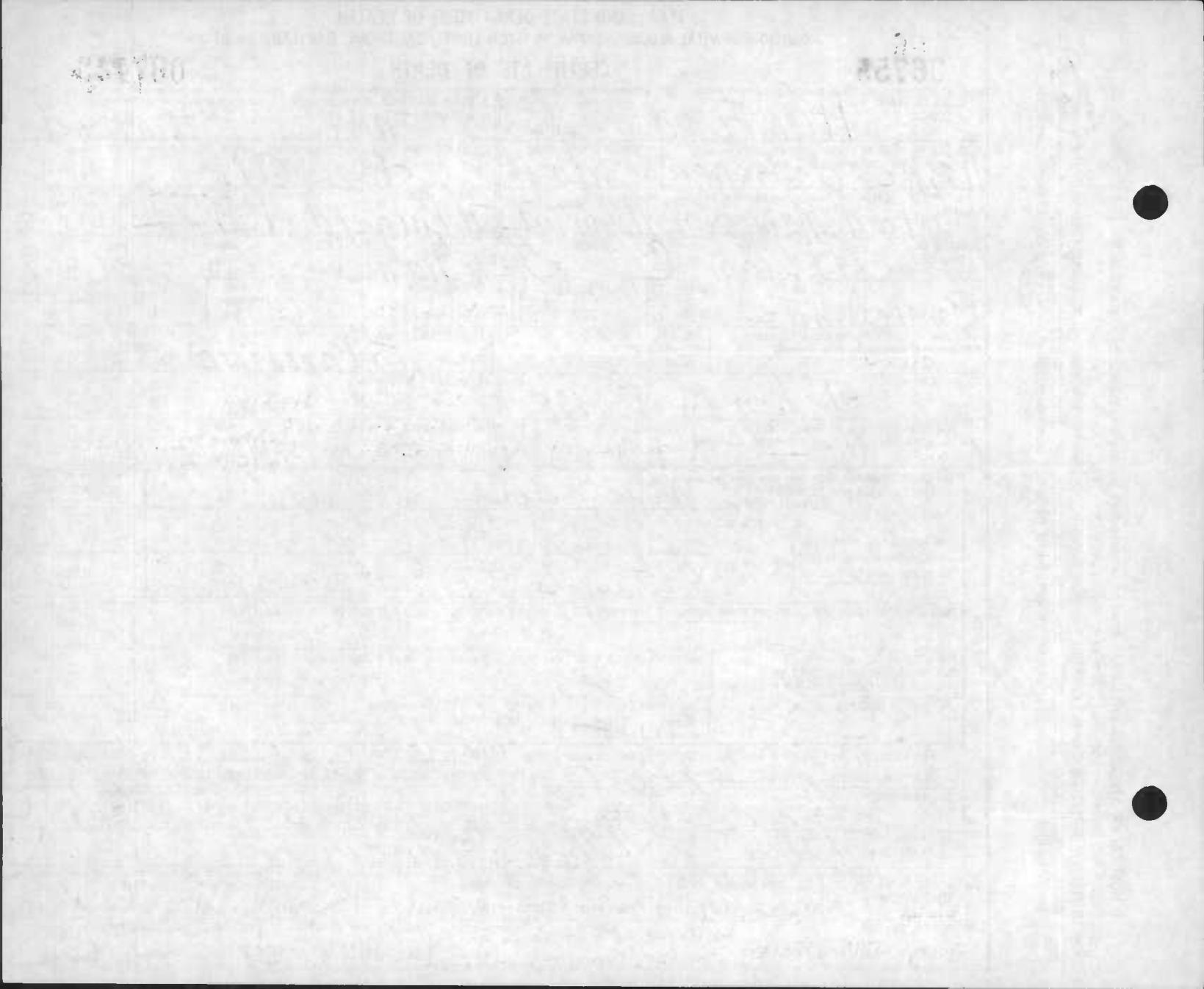
ADDRESS

DATE JUN 2 1967

Joseph William Foster

Bel Air, Maryland 21014

Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

06756

06743

1. PLACE OF DEATH  
e. COUNTY

HARFORD

MARYLAND

b. CITY OR TOWN (if outside corporate limits,  
write RURAL and give nearest town)

BEL AIR (RURAL)

c. LENGTH OF STAY IN lb

18 YRS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

RD#2 Box 289 SHUCKS CORNER

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

RICHARD COULSON TODD

4. SEX  
MALE6. COLOR OR RACE  
WHITE7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 8. DATE OF BIRTH  
23 Sep. 19044. DATE  
OF  
DEATH

MAY 31 1967

9. AGE (In years  
last birthday) 62  
yrs.IF UNDER 1 YEAR  
Months DeysIF UNDER 24 HRS.  
Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

FARMING

10b. KIND OF BUSINESS OR INDUSTRY  
Farm

11. BIRTHPLACE (State or foreign country)

Perryville, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROBERT TODD

14. MOTHER'S MAIDEN NAME

Margaret Coulson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

Yes WW-II

16. SOCIAL SECURITY NO.

17. INFORMANT

197-07-9737 GRACE TODD (WIFE) SAME

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,  
IMMEDIATE CAUSE (a)

ACUTE CORONARY Occlusion

INTERVAL BETWEEN  
ONSET AND DEATHLESS THAN  
10 MIN.

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH

2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m. While at work  Not While at work   
p.m. 1920d. INJURY OCCURRED  
While at work  Not While at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

2df. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes  Accident , Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

31 MAY 1967

DATE SIGNED

307 HICKORY AVE  
BEL AIR, MD

Address (Street, city, town, or county)

22e. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS  
Burial 13 June 67 Bel Air Memorial Gardens, Bel Air Maryland

22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR

Tarring Funeral Home

24e. REC'D BY REGISTRAR

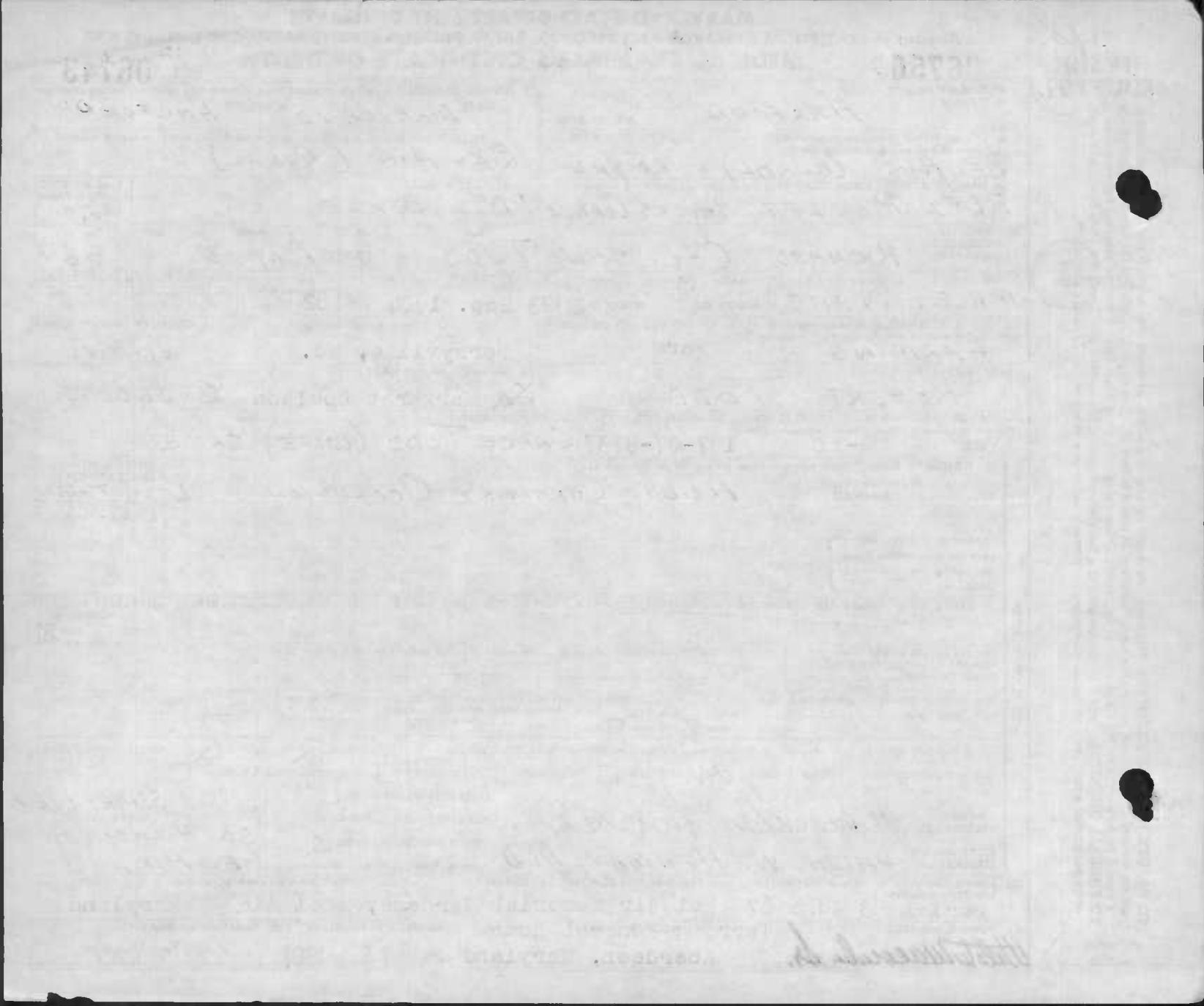
24b. REGISTRAR'S SIGNATURE

Hector Macoubre Sr.

Aberdeen, Maryland

DATE JUN 5 1967

Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

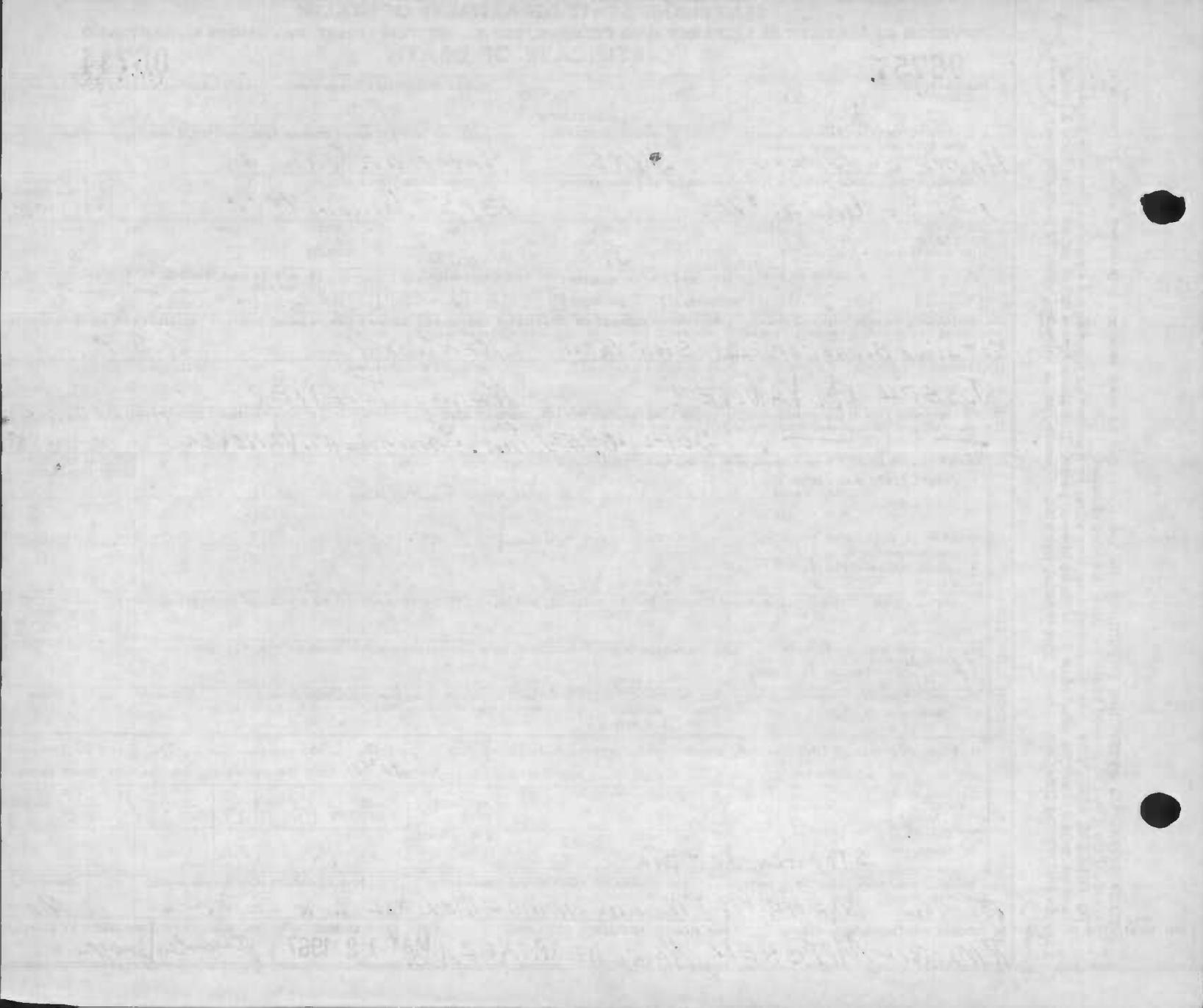
## CERTIFICATE OF DEATH

06744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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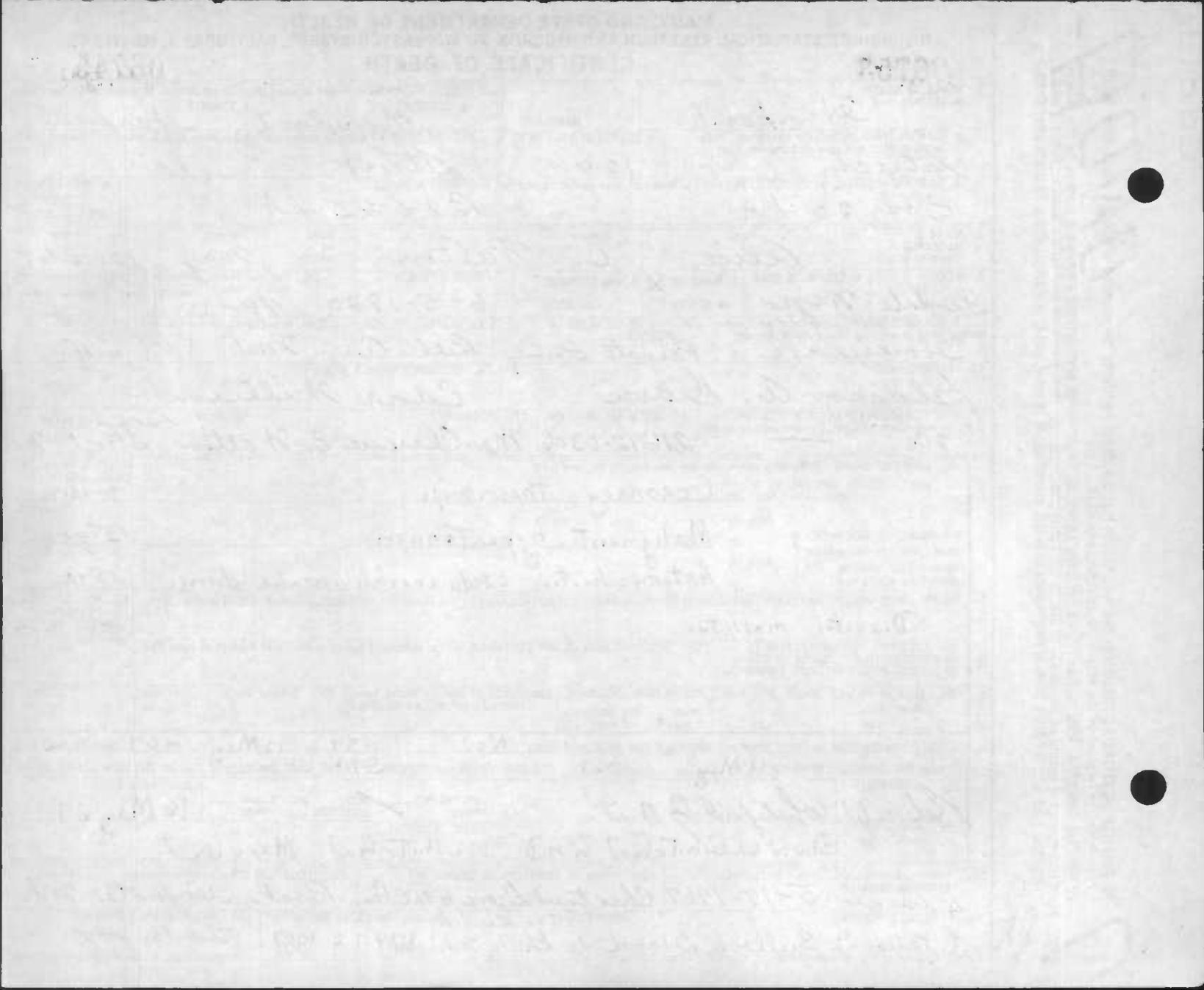
1. PLACE OF DEATH a. COUNTY		131 S. UNION AVENUE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		MD		b. COUNTY		Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD		c. LENGTH OF STAY IN lb 3 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD				d. STREET ADDRESS		131 So. Union AVE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 131 So. Union AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month	Day	Year		
Elijah J. VANOVER				Vanover		5	9	1967			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male		W	4-26-1909	58 yrs.		Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
SETALINE BURNER OPERATOR		SHIP YARD		KENTUCKY		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
JOSEPH G. VANOVER		NANCY TOLLIVER									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
		301-01-6957		Mr. Emigino M. VANOVER		HAVERDE GRACE		Respiratory Insufficiency		1	
18a. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		med. astinal		metast.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Branchiopneumonia		Carcinoma					
18b. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		(c)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at 10:30 P.M., from the causes and on the date stated above.											
22a. SIGNATURE		STEPHEN TURBIN		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-9-67	
22c. PHYSICIAN'S NAME (Type)		STEPHEN TURBIN		22d. ADDRESS		131 South Union Avenue					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)				(State)	
Burial		May 12, 1967		MEADOWBRIDGE MEMORIAL PARK		BALTIMORE, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
R. MADISON MITCHELL, HAVERDE GRACE, MD.				MAY 12 1967		CHARLES JUDGE					



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
06758				06745									
1. PLACE OF DEATH a. COUNTY		Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Street				a. STATE Maryland		b. COUNTY Harford					
c. LENGTH OF STAY IN 1b		10 mos.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Street					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Box 254 A				d. STREET ADDRESS		Box 254 A					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First Alice	Middle C.	Last Walton	4. DATE OF DEATH	Month May	Day 12	Year 1967					
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1920	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (County & State, or foreign country) Bel-Air, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Glasco A. Davis		14. MOTHER'S MAIDEN NAME Edna Williams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-12-0306		17. INFORMANT Mr. Clarence E. Walton, Street, Md.		Address Box 254 A			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Sudden											
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		15 yr.											
DUE TO (b) Malignant hypertension		15 yr.											
DUE TO (c) Arteriosclerotic cardio cerebro vascular disease		15 yr.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 1967, to 12 May 1967, that (I) (we) last saw the deceased alive on 12 May 1967, and that death occurred at 5:45 P.M., from the causes and on the date stated above.													
22a. SIGNATURE Edmund W. Whiteford Jr. M.D.		22b. DATE SIGNED 16 May 67											
22c. PHYSICIAN'S NAME (Type) Edmund W. Whiteford Jr. M.D.		M.O. ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-17-1967		23c. NAME OF CEMETERY OR CREMATORIAL Chestnut Grove A.M.E. Cemetery		23d. LOCATION (City, town or county) Rocks, Harford Co. Md.		(State)					
24. FUNERAL DIRECTOR Otelia J. Bullock, Haven de Grace, Md.		ADDRESS 556 Larch St.		25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

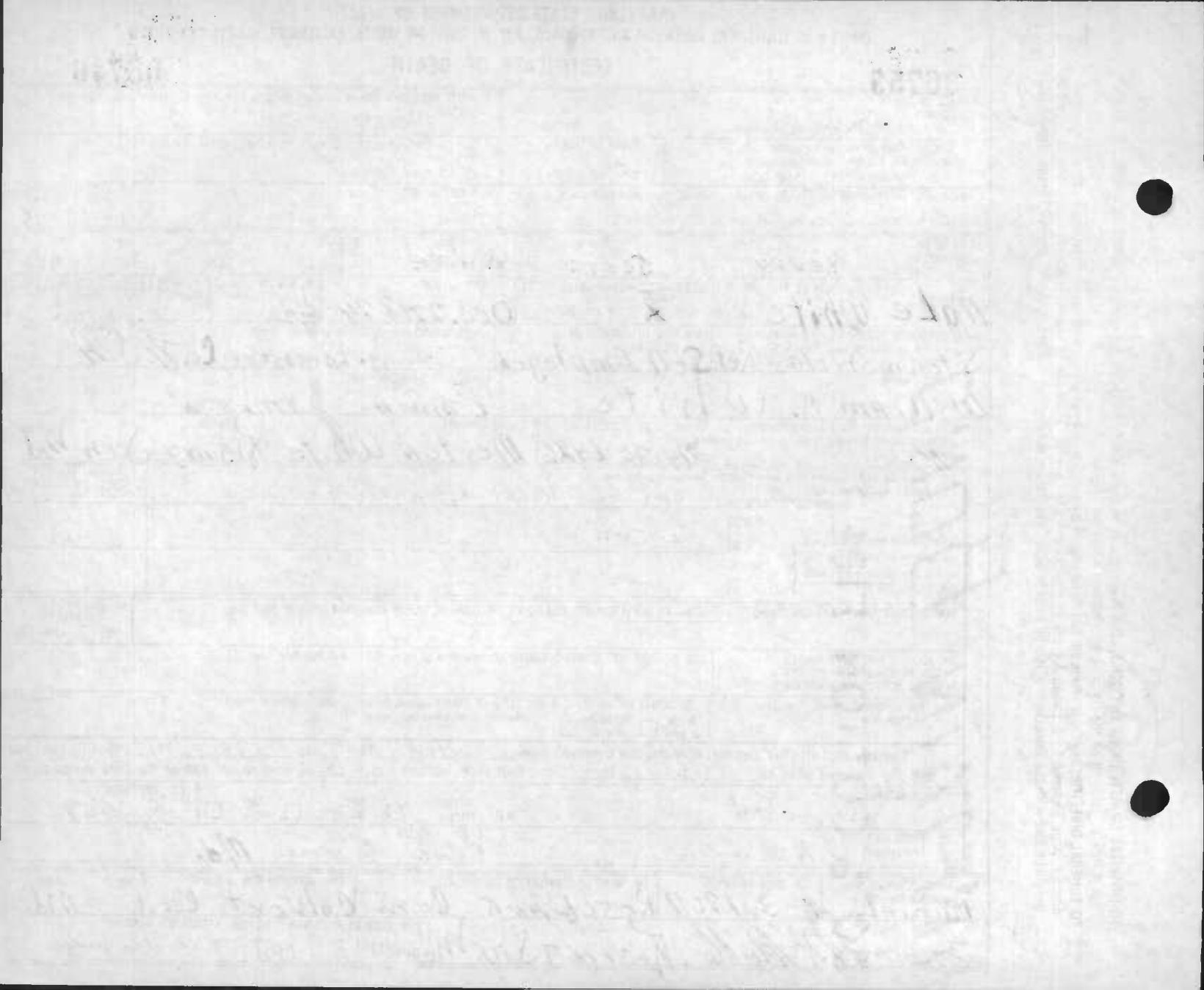
CERTIFICATE OF DEATH

05746

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY <i>Harford</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Haven de Grace</i>		c. LENGTH OF STAY IN lb <i>51 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Citizens Nursing Home</i>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <i>HENRY</i>	Middle <i>SCOTT</i>	Last <i>WHITE</i>	4. DATE OF DEATH Month <i>MAY</i>	Day <i>31</i>	Year <i>1967</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Dec. 22 1874</i>	9. AGE (In years last birthday) <i>92</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steam fitter Ret. Self Employed</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Penns. Lancaster C.A.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>C.A.S.A.</i>	
13. FATHER'S NAME <i>William K. White</i>		14. MOTHER'S MAIDEN NAME <i>Emma Jamison</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-30-6426</i>		17. INFORMANT <i>Merton White Rising Sun, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		Cardiac - Renal decompensation				INTERVAL BETWEEN QNSET AND DEATH <i>24 h</i>	
						<i>Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 4/10, 1967, to _____ 5/31, 1967, that (I) (we) last saw the deceased alive on _____ 5/31, 1967, and that death occurred at _____ 5:00 M, from causes and on the date stated above.							
22a. SIGNATURE <i>A.W. Grigoleit</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/31/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>A.W. GRIGOLEIT</i>		22d. ADDRESS <i>Haven de Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-3-1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Boise-Bank Cem Colvert Cecil Md.</i>		23d. LOCATION (City or Town) (County) (State) <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>Lemon E. Muller</i>				25a. REC'D BY REGISTRAR <i>JUN 5 1967</i>		25b. REGISTRAR'S SIGNATURE	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06760

## CERTIFICATE OF DEATH

06747

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS 42 Monroe Street	
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle		4. DATE OF DEATH Month WILLIS May 29 19 67	
5. SEX Female Negro		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 15 Aug. 1868		9. AGE (In years last birthday) 98 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mozella Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-52-7886 17. INFORMANT Address Elsie W. Ames, Aberdeen, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO C.V.A last. (c) DUE TO ASCVD			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MALNUTRITION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 7, 19 67, to May 29, 19 67, that (I) (we) last saw the deceased alive on May 29, 19 67, and that death occurred at 6:45 AM, from causes and on the date stated above.			
22a. SIGNATURE Kheyte Vidal		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 5-29-67	
22c. PHYSICIAN'S NAME (Type) Santiago Leyte-Vidal, M.D.		22d. ADDRESS 114 W. Bel Air Ave. Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3 June 67 23c. NAME OF CEMETERY OR CREMATORIUM Union Methodist Cemetery, Aberdeen, Md. 23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Jarrin		ADDRESS General Home 25a. REC'D BY REGISTRAR	
Aberdeen, Md.		25b. REGISTRAR'S SIGNATURE DATE JUN 2 1967 Charles Judge	

